

No. 300
10-47
5-17-39
1 3906

State File No.

FILED OCT 13 1948
Registration District No. 1485

Primary Registration District No. 5566

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Rural, Dent
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3 miles southeast of Viburnum
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 3 miles southeast of Viburnum
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Abner Crum

3. (b) If veteran, name war no

3. (c) Social Security No. _____

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

63 unknown _____ hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business _____

12. Name John M. Crum

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name Mary Crum

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Bureau of Census

(b) Address Washington D. C.

17. (a) burial (b) Date thereof 10-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ironton Mo.

18. (a) Signature of funeral director White Funeral Home

(b) Address White Ironton Mo.

19. (a) Oct 9 - 1948 (b) Mrs Elizabeth Logan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October Day 1
year 1948 hour 4 minute 00 P. M.

21. I hereby certify that I attended the deceased from by inquest duties, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>pneumonia</u>	
Due to _____	
Due to _____	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations _____	PHYSICIAN Underline the cause to which death should be charged statistically.
Of autopsy <u>none</u>	

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) SUPPLEMENTAL

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? NO

23. Signature Chas Hampton (Specify type of place) 3
Address Annapolis, Md (City or town) (State) (County) (Date signed) Oct 1 - 48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 1048-1258
Date Filed 10-11-48

JAN 17 1949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Arnel J. White
Licensed Embalmer No. 3012
P. O. Address Fortson, Va.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 145

Primary Registration District No. 5566

1. PLACE OF DEATH:

(a) County Iron
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Abner Cum

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) hr. min.

9. Birthplace (City, town, or county) (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 194 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Lobar pneumonia

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (e) Means of injury _____

23. Signature Chas Hampton (M.D. or other)

Address Campania, Mo. Date signed 10/16/47

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-29630
1948