S. No. 2
M—2-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 8 1948

Registration District No. 28

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Schwartz

State File No. 32563

Primary Registration District No. 2000

Registrar's No. 953

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 612 N. Park
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 3 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 39
(c) City or town: Springfield 6
(If outside city or town limits, write "RURAL")
(d) Street No.: 612 N. Park 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: William J. Crabbe
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male D
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: August (Month) 6 (Day) 1948 (Year)
8. AGE: Years ____ Months 2 Days 25 If less than one day ____ hr. ____ min.
9. Birthplace: Springfield (City, town, or county) Missouri D (State or foreign country)
10. Usual occupation: Infant
11. Industry or business ____
FATHER
12. Name: Max M. Crabbe
13. Birthplace: Fowler (City, town, or county) Indiana 1 (State or foreign country)
MOTHER
14. Maiden name: Elizabeth Buyske
15. Birthplace: Milwaukee (City, town, or county) Wisconsin 1 (State or foreign country)
16. (a) Informant: Max M. Crabbe
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/4/48 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Mary
18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 11-3-48 (Date received local registrar) (b) W E Hardy MD (Registrar's signature) 111

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov. day: 2
year: 1948 hour: 7 30 minute: A M.
21. I hereby certify that I attended the deceased from 8-6-48, 19__, to 10-26-48, 19__; that I last saw him alive on 10-26-48, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia, acute fulminating, bilateral	1 day
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 107
Of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

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: E. J. Schwartz (M. D. or other)
Address: Med. Arts Bldg. Springfield Date signed: 11-2-48

(Licensed Embalmer's Statement on Reverse Side)

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.....

This body was not embalmed.

Licensed Embalmer No.....

P. O. Address.....

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.