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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1948

Registration District No. 39

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35898

Primary Registration District No. 5222

Registrar's No. 211

1. PLACE OF DEATH:

(a) County: Cass

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

(c) Name of hospital or institution: 12 Miles S.W. of Harrisonville
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: At home
In this community: 64 yrs in Cass Co.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO. (b) County: Cass 19

(c) City or town: Freeman 0
(If outside city or town limits, write "RURAL")

(d) Street No.: 0
(If rural, give location) 0

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

If yes, name country:

3. (a) PRINT FULL NAME: John Chroninger

3. (b) If veteran, name war: No

3. (c) Social Security No. None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, ~~married~~, ~~divorced~~: Widowed

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: deceased

7. Birth date of deceased: Feb. (Month) 17 (Day) 1872 (Year)

8. AGE: Years 76 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace: Johnson Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer retired 3 years

11. Industry or business:

MOTHER FATHER

12. Name: Leonard Croninger

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

14. Maiden name: Mary Manship

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

16. (a) Informant: Mrs Nettie Coe Krell

(b) Address: Freeman, Mo.

17. (a) Burial (Burial, cremation or removal) (b) Date thereof: 12/3/48 (Month) (Day) (Year)

(c) Place: burial or cremation: Freeman Cemetery

18. (a) Signature of funeral director: Atkinson Bros

(b) Address: Harrisonville Mo.

19. (a) Dec. 3 1948 (Date received local registrar) (b) Lamar J. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1 year 1948 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from 11-27- 1948 to 11-30- 1948 that I last saw him alive on 11-30- 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Senility	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Edward S. Jones (M. D. or other) MD

Address: Harrisonville Mo. Date signed: 12-3-48

(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~~ personell

....., Registered Apprentice No.....

working under my personal supervision.

Signed Floyd Atkinson

Licensed Embalmer No. 3920

P. O. Address Harrisonville

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

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