

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **39324**

FILED DEC 29 1948

Registration District No. **22**Primary Registration District No. **5-115**Registrar's No. **88**

1. PLACE OF DEATH:

- (a) County **Bellingham**
 (b) City or town **Rural Whiteville**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Sedgwickville Mo R #11**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community _____
 years, months or days3. (a) PRINT
FULL NAME**CATHRINE CRITES**

3. (b) If veteran,

name war _____

3. (c) Social Security No.

4. Sex **F** 1. Color or race **W**
 6. (a) Single, widowed, married, divorced **0**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Feb 7 - 1945**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 **11** **8** hr. min.

9. Birthplace **Sedgwickville Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Earl Crites**
 13. Birthplace **Sedgwickville Mo.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Bergie Bart**
 15. Birthplace **Oriskany Beach Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Earl Crites**
 (b) Address **Sedgwickville Mo R 1**
 17. (a) **Burial** (b) Date thereof **Dec 17 1948**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Post Oak Cemetery**
 18. (a) Signature of funeral director **McComb & Huf**
 (b) Address **Jackson Mo**
 19. (a) **Dec 21/48** (b) **Millie Vandenberg**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo** (b) County **Bellingham**
 (c) City or town **Sedgwickville Mo**
 (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 **Dec** day **15th**
 year **1948** hour **2:30** minute **P** M.

21. I hereby certify that I attended the deceased from **Dec 15th** 19**48** to **Dec 15th** 19**48**
 that I last saw him alive on **Dec 15th** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pts. Mom's Passing

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause of
which death
should be
charged sta-
tistically.

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 **Edwin Crites** (M. D. **9**)
 Address **Sedgwickville Mo** Date signed **12/16/48**

RECEIVED

District Health Officer No. 4
District File Number 1248-1611
Date Filed 12-28-48

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 _____

Licensed Embalmer No. 3051

P. O. Address Jackson Mo.

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.