

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23161**

BIRTH NO. **27930-49** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466** Registrar's No. **671**

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>CHRISTIAN</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural - South Campbell Twp.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Nixa</b>	
c. LENGTH OF STAY (in this place) <b>5 1/2 hrs.</b>		d. STREET ADDRESS (If rural, give location) <b>HOME</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>OZARK OSTEOPATHIC HOSPITAL</b>		3. NAME OF DECEASED a. (First) <b>Paula Deane</b> b. (Middle) <b>Crain</b> c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <b>7-29-49</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Barry</b>	
8. DATE OF BIRTH <b>MAY 31, 1949</b>		9. AGE (In years last birthday) Under 1 Year: Months <b>1</b> Days <b>30</b> If under 1 hr. Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Paul Franklin Crain</b>		13b. MOTHER'S MAIDEN NAME <b>Berna Deane Perkins</b>	
14. NAME OF HUSBAND OR WIFE <b>NONE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Paul Crain - Nixa, Mo.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Medullary Paralysis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Bulbar poliomyelitis</b> DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>D400</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>7-29</b> , 19 <b>49</b> , to <b>7-29</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>7-29</b> , 19 <b>49</b> , and that death occurred at <b>6:45 a.m.</b> , from the causes and on the date stated above.	
23a. SIGNATURE <b>Richard E. Wetzel M.D.</b>		23b. ADDRESS <b>700 E. Sunshine Spfd. Mo.</b>	
23c. DATE SIGNED <b>7/29/49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24b. DATE <b>7/31/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Payne Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Christian Co., Mo.</b>		DATE REC'D BY LOCAL REG. <b>7/29/49</b>	
REGISTRAR'S SIGNATURE <b>W. Daudley M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John Dean Davis</b>	
ADDRESS <b>Clear Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 27 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

*John Dean Harris*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4390*

P. O. Address *Cleveland, 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.