

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27479

BIRTH NO. _____		REG. DIST. NO. <u>236</u>		PRIMARY REG. DIST. NO. <u>5818</u>		Registrar's No. <u>35</u>	
1. PLACE OF DEATH a. COUNTY <u>Morgan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Moreau Township</u>		c. LENGTH OF STAY (in this place) <u>70 Yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Moreau Township</u>		71 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3 M. N. E. Barnett</u>				d. STREET ADDRESS (If rural, give location) <u>3 M. N. E. Barnett</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>			b. (Middle) <u>Butler</u>		c. (Last) <u>Crutchfield</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 31, 1949</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>June 24, 1862</u>	
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>3</u>		IF UNDER 1 YEAR Days <u>7</u>		IF UNDER 1 HR. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Callaway Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Wesley Crutchfield</u>			13b. MOTHER'S MAIDEN NAME <u>Harriett Miller</u>			14. NAME OF HUSBAND OR WIFE <u>Sophia Kelsay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mabel Phillips High Point, Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>arterial occlusion 10 yrs</u>  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. <u>4/201</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)		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 <u>Aug 30, 1949</u> to <u>Aug 31, 1949</u> , that I last saw the deceased alive on <u>Aug 31, 1949</u> , and that death occurred at <u>3 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>A. J. Gunn M.D.</u>				23b. ADDRESS <u>Ursatile Mo</u>		23c. DATE SIGNED <u>Sept 1-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 2-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Versailles, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Sept 8-1949</u>		REGISTRAR'S SIGNATURE <u>J. L. Washburn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. T. Hummel</u>		ADDRESS <u>Versailles, Mo.</u>	

U.O.K.

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 12 1949

**RECEIVED**

District Health Officer No: 71

District File Number 8-49-1087

Date Filed 9-10-49

*not embalmed*

**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.

Student \_\_\_\_\_  
Student Embalmer

Signed Raymond C. Lorber

Licensed Embalmer No. 4626

P. O. Address Versailles, 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.