

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33651**

BIRTH NO. _____ REG. DIST. NO. **133** PRIMARY REG. DIST. NO. **4206** Registrar's No. **82**

1. PLACE OF DEATH a. COUNTY Harrison			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Harrison		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN New Hampton		c. LENGTH OF STAY (in this place) 1	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN New Hampton		4. DATE OF DEATH (Month) (Day) (Year) Oct 21 1949
d. FULL NAME OF HOSPITAL OR INSTITUTION Home in New Hampton Arch Street			d. STREET ADDRESS (If rural, give location) Arch Street		
3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) Amanda c. (Last) Crabtree			4. DATE OF DEATH (Month) (Day) (Year) Oct 21 1949		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH Dec 10 1872	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 10 Days 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Genl County Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John W. Miller		13b. MOTHER'S MAIDEN NAME Pollie McCury		14. NAME OF HUSBAND OR WIFE Gabral Crabtree Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Johnnie Crabtree Bethany MO		
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) Hemiplegia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 0		
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)		21f. HOW DID INJURY OCCUR?
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from _____, 19____, to Oct 21, 1949 , that I last saw the deceased alive on Oct 1, 1949 , and that death occurred at 5 P m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) J. Wilson M.D.			23b. ADDRESS New Hampton		23c. DATE SIGNED Oct 22 '49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 23 1949	24c. NAME OF CEMETERY OR CREMATORY Loan Star Cemetery	24d. LOCATION (City, town, or county) (State) Gentry County MO		
DATE REC'D BY LOCAL REG. Oct 31-49		REGISTRAR'S SIGNATURE Zola Burris	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. H. Noble New Hampton MO		

(Licensed Embalmer's Statement on Reverse Side)

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



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 me

Student Embalmer No.

working under my personal supervision.

Signed.....

W. S. Noble

Signed.....

Student Embalmer

Licensed Embalmer No. 2904

P. O. Address New Hampton

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.