

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **317**

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY OR TOWN Columbia		c. CITY OR TOWN Columbia	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) Route #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ellie Fischell Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Mae	b. (Middle) Evelena	c. (Last) Crane	4. DATE OF DEATH (Month) (Day) (Year) Dec. 20, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH May 6, 1928	9. AGE (In years last birthday) 21	10. MONTHS 7	11. DAYS 14	12. HOURS 14	13. MIN. 14
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse aide	10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (State or foreign country) Boone County Missouri	12. CITIZEN OF WHAT COUNTRY? USA.
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13a. FATHER'S NAME Crews Crane	13b. MOTHER'S MAIDEN NAME Lura	14. NAME OF HUSBAND OR WIFE Unmarried
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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. 722-14-8893	17. INFORMANT'S SIGNATURE OR NAME Walton Crane	ADDRESS Columbia
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stature thyrotoxicosis, resole		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.		273X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **19**, to **19**, that I last saw the deceased alive on **19**, and that death occurred at **7:30 P.m.** from the causes and on the date stated above.

23a. SIGNATURE Harry M. Griffith M.D.	(Degree or title)	23b. ADDRESS Columbia Mo	23c. DATE SIGNED 12-20-49
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24. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 23 1949	24c. NAME OF CEMETERY OR CREMATORY Nashville Cem	24d. LOCATION (City, town, or county) (State) Boone Co Mo
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DATE REC'D BY LOCAL REG. Dec 23 1949	REGISTRAR'S SIGNATURE Mrs R.E. Palmer	31	25. FUNERAL DIRECTOR'S SIGNATURE R. O'Connell	ADDRESS Columbia Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

District File Number _____
District Health Officer No. 9
RECEIVED DEC 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, ~~and~~ by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Lynnan H. Spunkle*

Licensed Embalmer No. *4013*

P. O. Address *Columbia, Mo.*

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

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