

FILED JAN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43461**

BIRTH NO. _____		REG. DIST. NO. 347		PRIMARY REG. DIST. NO. 4507		Registrar's No. 52	
1. PLACE OF DEATH a. COUNTY Stone				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stone			
b. CITY OR TOWN Crane		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN Crane		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		a. (First) H.		b. (Middle) S.		c. (Last) Priest	
4. DATE OF DEATH		(Month) Nov		(Day) 13		(Year) 1949	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept 14 1892	
9. AGE (In years last birthday) 77		if UNDER 1 YEAR Months 2 Days 29		if UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ky 1		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Miss Georgia John Munchater Iowa			
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) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) - II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none				INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 yrs. 4201	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		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 Nov-1- , 1949, to Nov-13- , 1949, that I last saw the deceased alive on 12-13- , 1949, and that death occurred at 4:30 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE H. L. Kerr M.D. (Degree or title)				23b. ADDRESS Crane Mo.		23c. DATE SIGNED 12-14-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/16/49		24c. NAME OF CEMETERY OR CREMATORY Hale		24d. LOCATION (City, town, or county) (State) Oak Grove Ark	
DATE REC'D BY LOCAL REG. Dec. 15-49		REGISTRAR'S SIGNATURE Lena Murray - Dep. C		25. FUNERAL DIRECTOR'S SIGNATURE George H. Moulton, Crane		ADDRESS Mo.	

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

RECEIVED JAN 3 1950

District Health Office No. 6,

District File Number 150-15

Date Filed 1-3-50

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, ~~only~~.....

..... Student Embalmer No.

working under my personal supervision.

Signed Doelin Salmon.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3177

P. O. Address Springfield 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.