

FILED MAR 12 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3824**
Registrar's No. **262**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | | c. LENGTH OF STAY (in this place) 50 years | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2519 Jules St. | | d. STREET ADDRESS (If rural, give location) 2519 Jules St. | |

| | | | | | |
|-------------------------------------|------------------------|-----------------------|--------------------------|---------------------------------------|---------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Mary | b. (Middle) R. | c. (Last) Crandal | 4. DATE OF DEATH (Month) (Day) (Year) | March 5 1951 |
|-------------------------------------|------------------------|-----------------------|--------------------------|---------------------------------------|---------------------|

| | | | | | | |
|----------------------|-------------------------------|---|---------------------------------------|---|---|--|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH Oct. 25, 1860 | 9. AGE (In years last birthday) 90 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 4 HRS. Hours 0 Min. 0 |
|----------------------|-------------------------------|---|---------------------------------------|---|---|--|

| | | | |
|--|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) Illinois | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|---|---|---|

| | | |
|---|--|--|
| 13a. FATHER'S NAME John Barnhart | 13b. MOTHER'S MAIDEN NAME Henrietta unknown | 14. NAME OF HUSBAND OR WIFE W. B. Crandal |
|---|--|--|

| | | | |
|---|-------------------------------|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME Mrs. W. M. Edson | ADDRESS 2519 Jules St. St. Joseph 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 2,903.0 20 |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture left hip. | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerotic disease. DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|--------------------------------------|--|---|
| 19a. DATE OF OPERATION 2-6-51 | 19b. MAJOR FINDINGS OF OPERATION Fracture left hip. | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--------------------------------------|--|---|

| | | |
|---|--|---|
| 21a. ACCIDENT (Specify) accident | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Joseph Buchanan Mo |
|---|--|---|

| | | |
|---|---|---|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 30 51 - m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? Fell at home. |
|---|---|---|

22. I hereby certify that I attended the deceased from **1-30, 1951**, to **3-5, 1951**, that I last saw the deceased alive on **3-5, 1951**, and that death occurred at **9:30 p. m.**, from the causes and on the date stated above.

| | | |
|---|--|--------------------------------|
| 23a. SIGNATURE Ronald M. Buck M.D. | 23b. ADDRESS 907 Edmund St. St. Joseph Mo | 23c. DATE SIGNED 3-6-51 |
|---|--|--------------------------------|

| | | | |
|---|-------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE 3/8/51 | 24c. NAME OF CEMETERY OR CREMATORY Hamburg Cemetery | 24d. LOCATION (City, town, or county) (State) Hamburg Iowa |
|---|-------------------------|--|---|

| | | | |
|---|---|---|-------------------------------|
| DATE REC'D BY LOCAL REG. March 9, 1951 | REGISTRAR'S SIGNATURE Carl E. Casper | 25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Brown Funeral Home | ADDRESS St. Joseph Mo. |
|---|---|---|-------------------------------|

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed

James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address 319 W. 10th St. Jones

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.