

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 31 1951

State File No. 42612
Registrar's No. 34

BIRTH NO. _____ REG. DIST. NO. 296 PRIMARY REG. DIST. NO. 6017

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) Camden Rural		c. CITY (If outside corporate limits, write RURAL and give township) Camden, Rural	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 0890	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED (Type or Print) Robert	b. (First)	b. (Middle)	c. (Last) Cringan	4. DATE OF DEATH (Month) (Day) (Year) Dec. 17 - 51
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 17, 1873	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Edinburg, Scotland	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Cringan	13b. MOTHER'S MAIDEN NAME Jean Wallace	14. NAME OF HUSBAND OR WIFE Anna Farris Cringan
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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. NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Agnes Vail	ADDRESS Orriok, Mo
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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 4 hours 4 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic arteriosclerosis 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	19b. MAJOR FINDINGS OF OPERATION 4214	20. AUTOPSY? YES <input 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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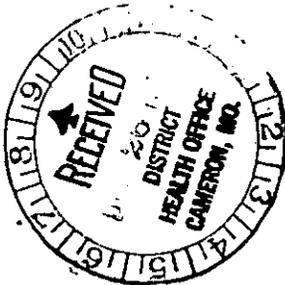
22. I hereby certify that I attended the deceased from **Nov 19, 1951**, to **Dec 19, 1951**, that I last saw the deceased alive on **Dec 10, 1951**, and that death occurred at **10:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Virgil E. Shode M.D.	(Degree or title)	23b. ADDRESS Orriok, Mo.	23c. DATE SIGNED 12-19-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 20, 51	24c. NAME OF CEMETERY OR CREMATORY South Point Cem	24d. LOCATION (City, town, or county) (State) 2 Mi E of Orriok, Mo.
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DATE REC'D BY LOCAL REG. 12-20-51	REGISTRAR'S SIGNATURE Helen J. Larkin	25. FUNERAL DIRECTOR'S SIGNATURE B. W. Good	ADDRESS Orriok, Mo.
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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

working under my personal supervision.

Self

Signed *Victor E. Leminger* Student Embalmer No.

Signed.....
Student Embalmer

Licensed Embalmer No. *2896*
P. O. Address *Liberty 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.