

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **25164**

FILED JUL 16 1952

BIRTH NO.		REG. DIST. NO. 228	PRIMARY REG. DIST. NO. 4342	Registrar's No. 10
1. PLACE OF DEATH a. COUNTY MONTGOMERY 1700		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo b. COUNTY Montgomery		
b. CITY OR TOWN Jonesburg		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) 1700	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0		
3. NAME OF DECEASED (Type or Print) WILLIAM PRESTON CRUMP		a. (First)	b. (Middle)	c. (Last)
4. DATE OF DEATH 7 5 52		4. DATE OF DEATH (Month) (Day) (Year)		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH March 9 1872	9. AGE (In years last birthday) 80
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Waverton Mo	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Daniel Crump		13b. MOTHER'S MAIDEN NAME Rachel Smith	14. NAME OF HUSBAND OR WIFE N. Ellen Crump	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME N. Ellen Crump Jonesburg 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHIAL PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 26 hrs.
ANTECEDENT CAUSES DUE TO (b) Carcinoma STOMACH		DUE TO (c) CHRONIC PROSTATIS		9 yrs.
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 151X			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)		
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 July 16 , 19 52 , to July 5 , 19 52 , that I last saw the deceased alive on July 5 , 19 52 , and that death occurred at 7 p. m. , from the causes and on the date stated above.				
23a. SIGNATURE James O. Helm MD		(Degree or title)	23b. ADDRESS New Florence Mo.	23c. DATE SIGNED 7-8-52
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE July 7 1952	24c. NAME OF CEMETERY OR CREMATORY Jonesburg	24d. LOCATION (City, town, or county) (State) Jonesburg Mo	
DATE REC'D BY LOCAL REG. July 8-52	REGISTRAR'S SIGNATURE Mrs. Mary Miller	20665	FUNERAL DIRECTOR'S SIGNATURE Jonesburg Mo.	

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

SEP 25 1952

JUL 24 1952

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. _____ Student Embalmer No. _____

Student Student Embalmer

Signed *Carl A. Duding*

Licensed Embalmer No. *4115*

P. O. Address *Jonestown 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.