

FILED NOV 17 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37633**

BIRTH NO.		REG. DIST. NO. 38		PRIMARY REG. DIST. NO. 3006		Registrar's No. 303	
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 (If outside corporate limits, write RURAL and give township) OR TOWN Columbia		c. LENGTH OF STAY (In this place) 11 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Centralia 0100			
d. FULL NAME OF HOSPITAL OR INSTITUTION Tyler Nursing Home				d. STREET ADDRESS (If rural, give location) West Singleton			
3. NAME OF DECEASED (Type or Print) a. (First) WILMOTH H. HENRIETTA		b. (Middle)		c. (Last) CRUMP		4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1952	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 1-18-1874	
9. AGE (In years last birthday) 78		10. MONTHS 78		11. DAYS 78		12. HOURS 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaking		11. BIRTHPLACE (City and State or Foreign Country) Andrain County, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas S. Wisdom			13b. MOTHER'S MAIDEN NAME Martha Gant			14. NAME OF HUSBAND OR WIFE Robert Smith Crump	
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Mattie Gay Crump, Saginaw, Michigan			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis of Right Middle Cerebral Artery ANTECEDENT CAUSES Middle Cerebral Artery DUE TO (b) Arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS 1) Generalized Arteriosclerosis 2) Obesity due to excess food					INTERVAL BETWEEN ONSET AND DEATH 14 days
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 332X					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.) None		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) -- -- --			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? None			
22. I hereby certify that I attended the deceased from 24 Oct., 1952, to 4 Nov., 1952 , that I last saw the deceased alive on 4 Nov., 1952 , and that death occurred at 2 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE E. P. Rodgers, M.D. (Degree or title) Elie P. Rodgers				23b. ADDRESS 101 W. Broadway Columbia, Missouri		23c. DATE SIGNED 10 Nov 52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-6-52		24c. NAME OF CEMETERY OR CREMATORY Centralia Cemetery		24d. LOCATION (City, town, or county) (State) Centralia, Missouri	
DATE REC'D BY LOCAL REG. Nov. 12 1952		REGISTRAR'S SIGNATURE Mrs R E Palmer		25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS Bill E. Meador Centralia Mo			

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

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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.

Student
Student Embalmer

Signed Bill J. Meador

Licensed Embalmer No. 4876

P. O. Address Centralia, Miss

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.