

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10372**

FILED MAR 17 1953

BIRTH NO. _____		REG. DIST. NO. <u>164</u>	PRIMARY REG. DIST. NO. <u>8032</u>	Registrar's No. <u>52</u>
1. PLACE OF DEATH a. COUNTY JOHNSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JOHNSON		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WARRENSBURG		c. LENGTH OF STAY (In this place) 2 month		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN NOBSTER 0510
d. FULL NAME OF HOSPITAL OR INSTITUTION NACE NURSING HOME		d. STREET ADDRESS (If rural, give location) General Delivery		
3. NAME OF DECEASED (Type or Print) a. (First) REBECCA		b. (Middle) ANN	c. (Last) CROWDER	4. DATE OF DEATH (Month) (Day) (Year) MAR 1 1953
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAR. 26 1880	9. AGE (In years last birthday) 72 # UNDER 1 YEAR Months II Days 5 # UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) KANSAS
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME FRANK W BURRIS		
13b. MOTHER'S MAIDEN NAME ABAGOL LISTON		14. NAME OF HUSBAND OR WIFE DECEASED		
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. Alf Cockrum Knobster 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bacterial Pneumonia Hypostatic		INTERVAL BETWEEN ONSET AND DEATH 3 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr Myocarditis		DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION 4222		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, shopping, etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Warrensburg Johnson, Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? ←
22. I hereby certify that I attended the deceased from Jan 20 1952 to Mar 1, 1953 that I last saw the deceased alive on Mar 1, 1953 and that death occurred at 9:15 a.m. , from the causes and on the date stated above.				
23a. SIGNATURE H. W. Crowe		23b. ADDRESS Kurb Noster Mo		23c. DATE SIGNED Mar 2-53
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 3/4/53		24c. NAME OF CEMETERY OR CREMATORY Shady Grove Cemetery
24d. LOCATION (City, town, or county) (State) near Brackett Mo		25. FUNERAL DIRECTOR'S SIGNATURE Fred Wilkinson		
DATE REC'D BY LOCAL REG. Mar 2, 1953		REGISTRAR'S SIGNATURE Sarunah Quilley		
26. FUNERAL HOME ADDRESS Fred Wilkinson Funeral Home				

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

JOHNSON COUNTY HEALTH DEPT.
MAR 10 1953

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

F. L. Schaefer

Licensed Embalmer No. 4513

P. O. Address Clinton 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.