

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **37969**

FILED OCT 20 1953

BIRTH NO. _____ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **4473** Registrar's No. **29**

0970

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

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) Blackburn	c. LENGTH OF STAY (In this place) 15 yr.	c. CITY (If outside corporate limits, write RURAL and give township) Blackburn 0970	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) Rosa b. (Middle) Root c. (Last) Crane	4. DATE OF DEATH (Month) (Day) (Year) Oct 9, 1953
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 11 - 1865	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months 11 Days 29	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Moravia Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Stephen Root	13b. MOTHER'S MAIDEN NAME Joanna Persons	14. NAME OF HUSBAND OR WIFE Edurn C. Crane
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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. none	17. INFORMANT'S SIGNATURE OR NAME Blackburn, Mo. Emily R. Lottendister ADDRESS: _____
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Panel disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carson of edna			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 442X4	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **Jan 6, 1946** to **Oct 9, 1953**, that I last saw the deceased alive on **Oct 9, 1953** and that death occurred at **9:50P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Doyles Kelley M.D.	23b. ADDRESS Waverly Mo	23c. DATE SIGNED 10-10-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-12-53	24c. NAME OF CEMETERY OR CREMATORY Centerville Cem.	24d. LOCATION (City, town, or county) (State) Centerville Iowa
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DATE REC'D BY LOCAL REG. 10/13/53	REGISTRAR'S SIGNATURE Dolly Anderson 293	25. FUNERAL DIRECTOR'S SIGNATURE H. J. Gader ADDRESS Higginsville Mo
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NOV 25 1959

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 Ray F. Wiegman

Signed _____
Student Embalmer

Licensed Embalmer No. 2883

P. O. Address Higgensville, Md

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.