

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39611**

FILED DEC 2 - 1953

BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 5655 Registrar's No. 342

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mt. Vernon</u>		c. LENGTH OF STAY (In this place) <u>574 days</u>	c. CITY OR TOWN <u>Sikeston</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u>			e. STREET ADDRESS (If rural, give location) <u>Route 3</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Merle</u> b. (Middle) _____ c. (Last) <u>Croom</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23, 1953</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-24-12</u>		9. AGE (In years last birthday) <u>41</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) / <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>G. E. Pilquist</u>		13b. MOTHER'S MAIDEN NAME <u>Allie Callons</u>		14. NAME OF HUSBAND OR WIFE <u>Miller M. Croom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. <u>None known</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital records, Mo. S.S., Mt. Vernon, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary embolus, severe</u>	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS <u>Pulmonary tuberculosis, left upper lobe, lobectomy, post-operative</u> abt. 2 yrs.
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" 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) <u>002 X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	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 <u>4 - 27 - 1952</u> , to <u>11 - 23 - 1953</u> , that I last saw the deceased alive on <u>11 - 23 - 1953</u> , and that death occurred at <u>2:00 am.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>W. W. Polk MD</u>			23b. ADDRESS <u>Mt. Vernon, Mo.</u>		23c. DATE SIGNED <u>11-23-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>11-23-53</u>	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Wardville, Mo. Arkansas</u>	
DATE REC'D BY LOCAL REG. <u>11-23-53</u>	REGISTRAR'S SIGNATURE <u>Cecil Hendricks</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. L. Foust</u>		

(Licensed Embalmer Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Max L. Fournet*.....

Licensed Embalmer No. *4252*.....

P. O. Address *Altamonte Springs, Fla.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.