

FILED DEC 21 1953 14627 STANDARD CERTIFICATE OF DEATH

State File No. 42703

BIRTH NO. _____		REG. DIST. NO. 141		PRIMARY REG. DIST. NO. 3025		Registrar's No. 10	
1. PLACE OF DEATH a. COUNTY HOWELL				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY OREGON			
b. CITY OR TOWN WEST PLAINS		c. LENGTH OF STAY at this place 3DA.		c. CITY OR TOWN ALTON		0970	
d. FULL NAME OF HOSPITAL OR INSTITUTION CHRISTA HOGAN HOSP.				d. STREET ADDRESS (If rural, give location) STAR RT			
3. NAME OF DECEASED (Type or Print) a. (First) FREITA b. (Middle) RUTH c. (Last) CRITES			4. DATE OF DEATH (Month) (Day) (Year) 11-11-53				
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 3-25-53		9. AGE (In years last birthday) 7	IF UNDER 1 YEAR Months 7 Days 6	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) WEST PLAINS Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME A.E. CRITES		13b. MOTHER'S MAIDEN NAME Alma H. Heston		14. NAME OF HUSBAND OR WIFE 			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. 		17. INFORMANT'S SIGNATURE OR NAME A.E. Crites ADDRESS Alton 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital cerebral hemorrhage DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19a. DATE OF OPERATION		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, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		7710	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 3-25 , 19 53 , to 11-11 , 19 53 , that I last saw the deceased alive on 11-11-53 , 19 , and that death occurred at 2:50A m., from the causes and on the date stated above.							
23a. SIGNATURE A. Callahan M.D. (Degree or title)				23b. ADDRESS WEST PLAINS, Mo.		23c. DATE SIGNED 11/17/53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 11/13-53	24c. NAME OF CEMETERY OR CREMATORY FRANCIS		24d. LOCATION (City, town, or county) (State) Call. Mo		
DATE REC'D BY LOCAL REG. 12-15-53		REGISTRAR'S SIGNATURE Beatrice Cook		25. FUNERAL DIRECTOR'S SIGNATURE Robertson ADDRESS West Plains Mo		379	

(Licensed Embalmer's Statement on Reverse Side)

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

0461

STATEMENT BY LICENSED EMBALMER

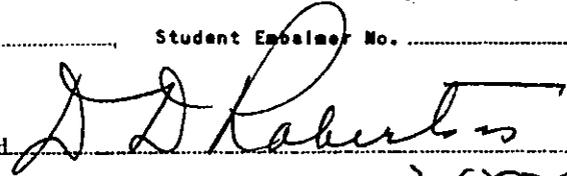
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 3427

P. O. Address West Plains

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.