

FILED APR 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7382**
Registrar's No. **252**

BIRTH NO. _____		REG. DIST. NO. 43		PRIMARY REG. DIST. NO. 3007		Registrar's No. 252	
1. PLACE OF DEATH a. COUNTY Butler				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Butler			
b. CITY OR TOWN Poplar Bluff		c. LENGTH OF STAY (If this place) 73		c. CITY OR TOWN Poplar Bluff		0124	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1037 Garfield				d. STREET ADDRESS (If rural, give location) 1037 Garfield			
3. NAME OF DECEASED (Type or Print) Katie			a. (First)	b. (Middle)	c. (Last) Crite	4. DATE OF DEATH (Month) (Day) (Year) 3 31 1955	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 3-13-1875		9. AGE (In years) 80	IF UNDER 1 YEAR Month 0 Day 17	IF UNDER 24 HRS. Hours _____ Min. _____
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 (City and State or Foreign Country) North Car.		12. CITIZEN OF WHAT COUNTRY USA.	
13a. FATHER'S NAME Lona Powers			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Deceased		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Olis Roberts Poplar Bluff, Mo.		ADDRESS _____	
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) Cardiac decompensation		ANTECEDENT CAUSES				1 Week	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Hypertensive Heart Disease				?	
		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					
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) 443X			
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 _____			
22. I hereby certify that I attended the deceased from Sept 1954 , to 31 Mar, 1955 , that I last saw the deceased alive on 30 Mar, 1955 , and that death occurred at 3:21 AM. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) W. D. Crocker MD				23b. ADDRESS 321 Oak Poplar Bluff, Mo. 64601		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE April 4, 55		24c. NAME OF CEMETERY OR CREMATORIUM City		24d. LOCATION (City, town, or county) (State) Poplar Bluff, Mo.	
DATE REC'D BY LOCAL REG. 4/7/55		REGISTRAR'S SIGNATURE D. D. Mueller		25. FUNERAL DIRECTOR'S SIGNATURE Judith Smith, Directors, Mo.			

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

RECEIVED
APR 11 1955

BUTLER CO. HEALTH CENTER

FILE No. _____

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

Frank Smith

Licensed Embalmer No. *4405*

P. O. Address *Leicester, 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.