FILED OCT 31 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 32987

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 325

1. PLACE OF DEATH
a. COUNTY Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim-Smith Hospital & Clinic — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Schuyler
c. CITY OR TOWN Lancaster — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First John; Middle Lee; Last Crim

4. DATE OF DEATH: Month October; Day 20; Year 1956

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH Nov. 25, 1874

9. AGE (In years last birthday) 81 — 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) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (City and state or country) Bloomfield, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Elias Crim

14. MOTHER'S MAIDEN NAME Elizabeth Boley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Hospital Records Address Lancaster Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertension — 5 yrs
DUE TO (c) Arteriosclerosis — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Oct 2, 1956, to Oct. 10, 1956 and last saw him alive on Oct 20, 1956. Death occurred at 4:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Milton T. English MD

22b. ADDRESS Kirksville, Mo

22c. DATE SIGNED 10-22-56

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Oct 23-56

23c. NAME OF CEMETERY OR CREMATORY IOOF

23d. LOCATION (City, town, or county) Lancaster (State) Mo

24. FUNERAL DIRECTOR Moreland-Norman ADDRESS Lancaster Mo

25. DATE RECD. BY LOCAL REG. 10-25-56

26. REGISTRAR'S SIGNATURE Kate Lambert

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

JUN 3 1 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Nova E. Foster

Licensed Embalmer No. 474

P. O. Address Kirkwell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.