

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3562**

FILED JAN 28 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **378** PRIMARY REG. DIST. NO. **4552** Registrar's No. **4**

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WRIGHT</b> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>MTM GROVE</b> c. LENGTH OF STAY (In this place) <b>6 WKS</b> d. FULL NAME OF HOSPITAL OR INSTITUTION <b>AVARON NURSING HOME</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>WEBSTER</b> c. CITY OR TOWN <b>CEDAR GAP</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> • STREET ADDRESS (If rural, give location) <b>EAST OF SEYMOUR</b>				
<b>3. NAME OF DECEASED</b> (Type or Print) <b>TERRY C. CRAIN</b> a. (First) <b>TERRY</b> b. (Middle) <b>C.</b> c. (Last) <b>CRAIN</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>1 - 10 - 57</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>8-13-1870</b>	<b>9. AGE (In years last birthday)</b> <b>86</b>	<b>IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>27</b> Hours <b>1</b> Mins. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Railroading</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>RAILROAD</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>DOUGLAS COUNTY MO</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>GEORGE WASHINGTON CRAIN</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>MANDA PARSONS</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>ROSE CRAIN CEDAR GAP MO</b>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NO</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>DELLA STREET SEYMOUR MO</b>		<b>ADDRESS</b> <b>DELLA STREET SEYMOUR MO</b>
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Cerebral Arteriosclerosis</b> <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis Hypertensive</b> DUE TO (c) _____ <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Not known</b> <b>300 hours</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>334x</b>			<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from Dec 1, 1956, to 1-10, 1957, that I last saw the deceased alive on 1-8, 1957, and that death occurred at 1:15 P. M., from the causes and on the date stated above.</b>						
<b>23a. SIGNATURE</b> <b>[Signature]</b> (Degree or title) <b>M.D.</b>			<b>23b. ADDRESS</b> <b>Mountain Grove Mo</b>		<b>23c. DATE SIGNED</b> <b>1-18-57</b>	
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>24b. DATE</b> <b>1-12-57</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>MASONIC</b>		<b>24d. LOCATION (City, town, or county) (State)</b> <b>SEYMOUR Missouri</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>1-18-57</b>		<b>REGISTRAR'S SIGNATURE</b> <b>[Signature]</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>[Signature]</b>		<b>ADDRESS</b> <b>SEYMOUR MO</b>

348

RECEIVED 1-22-57  
WRIGHT CO. HEALTH DEPT.  
County File Number 127-9  
Date Filed 1-26-57

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 *Alon G. Ferrell*.....

Licensed Embalmer No. *4847*

P. O. Address *Manfield, Ohio*

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.