

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5785 25442
STATE FILE NUMBER

FILED AUG 8 1957

Registration District No. 217 Primary Registration District No. ~~108~~ 8 Registrar's No. 55

1. PLACE OF DEATH a. COUNTY Mississippi			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bertrand		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY TOWN Bertrand		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence Route # 1 Life		Length of stay in lb # 1 Life	d. STREET ADDRESS (If outside, give location) Route # 1		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First IRA Middle WILLIAM Last CRANICK			4. DATE OF DEATH Month JULY Day 19 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1905	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months 11 Days 19 Hours 19 Mins 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Crowder, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Cranick			14. MOTHER'S MAIDEN NAME Roxi Sifford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 493-30-8968		17. INFORMANT Mrs. Mable Cranick Bertrand, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 3-16-57 to 6-25-57 and last saw her/him alive on 6-25-57 Death occurred at 7-20-57 m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Alfred B. Barger M. D.			22b. ADDRESS Sikeston, Missouri		22c. DATE SIGNED 7-20-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. NAME OF CEMETERY OR CREMATORY Armour Cemetery	23c. LOCATION (City, town, or county) (State) Bertrand, Missouri		
24. FUNERAL DIRECTOR Nunnelee Funeral Chapel		ADDRESS Sikeston	25. DATE RECD. BY LOCAL REG. 8-1-57	26. REGISTRAR'S SIGNATURE Clorath B. Haddon	

RECEIVED
Miss. Co. Health Dept
County File No. _____
Date Filed 8/7/57

AUG 8 1957

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 Philip J. Cassady
Licensed Embalmer No. 46

P. O. Address Helena,

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.