

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 9 - 1957

39244  
STATE FILE NUMBER  
1317

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1317

S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mercer</b>	
b. CITY OR TOWN <b>St. Joseph</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mill Grove</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>	Length of stay in lb <b>6 Mons.</b>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Crutcher</b> Last <b>Crutcher</b>	4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1957</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1876</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Deceased</b>	13b. MOTHER'S MAIDEN NAME <b>Deceased</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>488-22-9956</b>	17. INFORMANT <b>Woodrow Michael Princeton, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Flu-Pneumonia (bronchial)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic anemia</b>	<b>Unknown</b>
	DUE TO (c) <b>480X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Patient State Hosp #2 since May 14, 1957. Chronic Brain syndrome</b>		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.) <b>with senile brain disease.</b>
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20c. TIME OF INJURY Hour <b>9:25 A</b> Month, Day, Year <b>Nov. 26, 1957</b>	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 <b>Princeton, Missouri</b>
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21. I attended the deceased from <b>Nov. 19, 1957</b> to <b>Nov. 26, 1957</b> and last saw <sup>him</sup> <del>her</del> alive on <b>Nov. 25, 1957</b> . Death occurred at <b>9:25 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>H F Mundy M D</b>	22b. ADDRESS <b>St Joseph Mo</b>	22c. DATE SIGNED <b>Nov 26-1957</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 26, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Noel Moss Funeral Home</b>	23d. LOCATION (City, town, or county) (State) <b>Princeton, Missouri</b>
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24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Dec. 2, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Mrs Robert Fulton</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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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 *Bill Chaney* .....

Licensed Embalmer No. 4679 .....

P. O. Address ..... St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.