

MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007151

FILED VS FEB 29 1960 385

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3039 Registrar's No. 100

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| 1. PLACE OF DEATH a. COUNTY Linn | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Linn | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marceline, Mo. | | c. CITY OR TOWN New Boston, Mo. | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL St. Francis Hospital | | d. STREET ADDRESS (If outside, give location) | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First William Middle Everett Last Crist | | | 4. DATE OF DEATH Month February Day 12 Year 1960 | | |
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|-----------------------|----------------------------------|---|--|-------------------------------------|---|--|
| 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 22, 1894 | 9. AGE (last birthday) 65 | IF UNDER 1 YEAR Months 4 Days 20 | IF UNDER 24 HR Hours 0 Min. 0 |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | 10b. KIND OF BUSINESS OR INDUSTRY Own Barber Shop | 11. BIRTHPLACE (City and state or country) North Salem, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME George Crist | 13b. MOTHER'S MAIDEN NAME Nancy Cordray | 14. NAME OF HUSBAND OR WIFE Erna Crist |
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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) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs. Erna Crist, New Boston, Mo. | Address |
|---|-------------------------|--|---------|

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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Pneumonitis | | |
| DUE TO (b) Arteriosclerotic cardiovascular disease | | |
| DUE TO (c) with severe decompensation | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Asphyxia | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ |
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|---|--|--|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ |
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21. I attended the deceased from _____ to _____ and last saw him alive on **2-12-60**
Death occurred at **9:30 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-------------------|---------------------------------------|------------------------------------|
| 22a. SIGNATURE <i>George J. [Signature]</i> | (Degree or title) | 22b. ADDRESS Marceline, Mo. | 22c. DATE SIGNED 2-17-60 |
|--|-------------------|---------------------------------------|------------------------------------|

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|--|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Feb. 11, 1960 | 23c. NAME OF CEMETERY OR CREMATORY New Boston Cemetery | 23d. LOCATION (City, town, or county) (State) New Boston, Mo. |
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| 24. FUNERAL DIRECTOR Larson Funeral Service, Bucklin, Mo. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 2-13-60 | 26. REGISTRAR'S SIGNATURE Brookie Owens |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 1

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. A. Larson

Licensed Embalmer No. 4037

P. O. Address Bucklin, Missouri

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.

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