

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010165

FILED VS MAR 28 1960

53

Primary Registration District No. 3010

Registrar's No. 124

STATE FILE NUMBER

INDEXED

DOCUMENT

1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Cape Gir					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		Length of stay in 1b 8 mo.		c. CITY OR TOWN Oak Ridge		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Miller Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) None		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Presha Middle Crain Last Crain				4. DATE OF DEATH Month March Day 20 Year 1960					
5. SEX Fe	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Aug 2, 1875	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Kurreville, Mo		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Henry Reihn			13b. MOTHER'S MAIDEN NAME Lucinda Mayfield			14. NAME OF HUSBAND OR WIFE D. L. Crain			
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 Address Ellis Crain Oak Ridge, 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) Arterio Sclerotic Ht Disease							INTERVAL BETWEEN ONSET AND DEATH 23hr 49m.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Emphysema						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			
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 _____ a.m. _____ p.m.	Month, Day, Year _____								
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 1959 to 3/20/60 and last saw her alive on Mar 1 1960 Death occurred at 6AM 3/20/60 m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) H. S. Ridings md				22b. ADDRESS Cape Girardeau Mo				22c. DATE SIGNED 3/21/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 22, 60	23c. NAME OF CEMETERY OR CREMATORY Old Salem		23d. LOCATION (City, town, or county) Cape Girardeau Countym, Mo				
24. FUNERAL DIRECTOR St. Cloud Funeral Home, Mo.				25. DATE RECD. BY LOCAL REG. 3-25-1960		26. REGISTRAR'S SIGNATURE Drew Kasten			

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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 *[Signature]*

Licensed Embalmer No. 432

P. O. Address *Jackson, Miss*

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.