

# R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 9 1960

**-60-014696**

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 41

1. PLACE OF DEATH a. COUNTY <b>Dent</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Boss</b>		Length of stay in 1b <b>4 Mo's</b>		c. CITY OR TOWN <b>Boss</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>Home</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Boss, Mo. 1/2 Mi. W. Hwy. 32</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL LEOMAN CROCKER</b>				4. DATE OF DEATH Month Day Year <b>May 4, 1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-2-1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millwright</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Ozark Ore Co.</b>		11. BIRTHPLACE (City and state or country) <b>Goodwater, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>William Crocker</b>			13b. MOTHER'S MAIDEN NAME <b>Flora Graves</b>			14. NAME OF HUSBAND OR WIFE <b>Delia G. Crocker</b>			
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>499-03-5757</b>		17. INFORMANT Address <b>Mrs. Delia Crocker Boss, Missouri</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Due to natural causes</i> <i>(Investigated by Coroner)</i> DUE TO (b) _____ 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)						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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Martin Mart</i> (Degree or title) <i>(Local Registrar)</i>				22b. ADDRESS <i>Salem Mo.</i>				22c. DATE SIGNED <i>5/5/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-7-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Goodwater</b>		23d. LOCATION (City, town, or county) <b>Goodwater, Missouri</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Shipman &amp; Sons Bismarck, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>5/5/60</b>		26. REGISTRAR'S SIGNATURE <i>M.M. Stark, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 10

**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 John N. Shipman

Licensed Embalmer No. 4881

P. O. Address Bismarck,

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.