

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046739

ED VS JAN 3 1961 No. 385 Primary Registration District No. 3039 Registrar's No. 170 STATE FILE NUMBER

| | | | | | | | | | |
|--|---|---|--|---|---|--|--|--|--|
| 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. | | Length of stay in 1b 4 Years | | c. CITY OR TOWN Bucklin, Mo. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 118 West Howell Street | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Fred Middle Tillman Last Crippin | | | | 4. DATE OF DEATH Month December Day 30 Year 1960 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 3/10/1888 | 9. AGE (last birthday) 72 | | IF UNDER 1 YEAR Months 9 Days 20 | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (City and state or country) Belton, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Nathan Crippin | | | 13b. MOTHER'S MAIDEN NAME Martha Winters | | | 14. NAME OF HUSBAND OR WIFE Maggie Crippin | | | |
| 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. 486-12-7369 | | 17. INFORMANT Mrs Maggie Crippin, | | | Address 118 West Howell; Marceline, 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) Acute myocardial Infarction | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hours | | |
| DUE TO (b) Generalized Arteriosclerosis and cardiovascular disease | | | | | | | Indefinite | | |
| DUE TO (c) _____ | | | | | | | | | |
| 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 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 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 | |
| 21. I attended the deceased from 12/29/60 to 12/30/60 and last saw her/him alive on 12/30/60 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. Time 8:30 AM | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Stennon A. Zerner M.D. | | | | 22b. ADDRESS Marceline, Mo. | | | 22c. DATE SIGNED 12/31/60 | | |
| 25a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE JAN. 1, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery | | 23d. LOCATION (City, town, or county) Bucklin, Mo. | | 23e. STATE Mo. | | | |
| 24. FUNERAL DIRECTOR Larson Funeral Service, Bucklin, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 12-31-60 | | 26. REGISTRAR'S SIGNATURE Broonie Owens | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 17 1961

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 W. A. Larson

Licensed Embalmer No. 4037

P. O. Address Bucklin, 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.