

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

158-61-033707

AMENDED

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

FILED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <b>Nodaway</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Nodaway</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clearmont</b>		Length of stay in 1b <b>1 month</b>	c. CITY OR TOWN <b>Burlington Jct.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Raymond Hopple Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>none</b>	
3. NAME OF DECEASED (Type or print) First <b>MARINA</b> Middle <b>HELENA</b> Last <b>CRANE</b>			4. DATE OF DEATH Month <b>10</b> Day <b>4</b> Year <b>61</b>		
5. SEX <b>Female</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>1/24/65</b>	9. AGE (last birthday) <b>94</b>	IF UNDER 1 YEAR Months _____ Days _____
					IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Quitman, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Thomas King</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Peters</b>		14. NAME OF HUSBAND OR WIFE <b>Alfred B. Crane, dec.</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>none</b>	17. INFORMANT Address <b>Miss Anna Crane, Quincy, Illinois</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular thrombosis -</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1-2 wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>					<b>20 yrs</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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 <b>1958</b> to <b>10/4/61</b> and last saw her <b>9/18/61</b> live on <b>1:15</b> A. M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>[Signature]</b> M. D.			22b. ADDRESS <b>Maryville, Missouri</b>		22c. DATE SIGNED <b>10/6/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>10/6/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ohio</b>	23d. LOCATION (City, town, or county) <b>Burlington Jct., Mo.</b>		
24. FUNERAL DIRECTOR <b>Price Funeral Home, Maryville, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-6 61</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
SHOULD READ  
ITEM NO.

**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 Clara M. Price

Licensed Embalmer No. 1822

P. O. Address Maryville 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.