

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039856

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 347 Primary Registration District No. _____ Registrar's No. _____

FILED OCT 25 1961

1. PLACE OF DEATH a. COUNTY <u>Stone</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salena mo Br-3</u>		c. CITY OR TOWN <u>Salena mo Br.</u>	
Length of stay in 1b _____		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If outside, give location) _____	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Jon</u> Middle <u>J</u> Last <u>Crabtree</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1961</u>		
--	--	--	---	--	--

5. SEX <u>m</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26 - 63-9-8</u>	9. AGE (last birthday) <u>63-9-8</u>	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)) <u>Common Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Co. mo</u>	11. BIRTHPLACE (City and state or country) <u>Mo. U.S.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
---	--	---	--

13a. FATHER'S NAME <u>Irvin Crabtree</u>	13b. MOTHER'S MAIDEN NAME <u>Lucinda Stalton</u>	14. NAME OF HUSBAND OR WIFE <u>Pearl Crabtree</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	17. INFORMANT <u>Mrs Pearl Crabtree Auburn Calif</u>	Address <u>769 Mary Knapp</u>
---	---	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
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) _____	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 _____ Month, Day, Year _____ a.m. _____ p.m. _____

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 <u>Salena mo</u>	COUNTY _____ STATE _____
--	--	--	--------------------------

21. I attended the deceased from about 7: A.M. and last saw her alive on the date stated above, and to the best of my knowledge, from the causes stated.
Death occurred at _____

22a. SIGNATURE <u>LeRoy W. Cronin</u>	(Degree or title) <u>Coronary Coroner mo</u>	22b. ADDRESS <u>Salena mo</u>	22c. DATE SIGNED <u>10/18/61</u>
--	--	----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 17 - 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salena</u>	23d. LOCATION (City, town, or county) (State) <u>Salena mo</u>
--	-----------------------------------	---	---

24. FUNERAL DIRECTOR <u>Ernest J. Cheatham</u>	ADDRESS _____	25. DATE REGD. BY LOCAL REG. <u>Oct 21 - 61</u>	26. REGISTRAR'S SIGNATURE <u>Mrs J. E. ...</u>
---	---------------	--	---

DATE AMENDED

INSIDE OF

DOCUMENT

MEDICAL CERTIFICATION

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Salina, 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.