

WHILE EXHIBIT - USE CURVING BLACK INK - MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED APR 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11082

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 7
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days 1 yr

3. (a) PRINT FULL NAME Julia H Crome

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife Wm F Crome 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 1 1858
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace St Louis mo
(City, town, or county) (State or foreign country)

10. Usual occupation Home work

11. Industry or business _____

MOTHER FATHER { 12. Name Conrad Fink } 6

13. Birthplace Germany } 6
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Metz

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Alice Crome

(b) Address Clinton mo

17. (a) Burial (b) Date thereof 3-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood cem

18. (a) Signature of funeral director Consalus & Pank

(b) Address Clinton mo

19. (a) 3-9-40 (b) Dr J B Hampton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 9 (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month First day March
year 1940 hour 8:50 minute A M.

21. I hereby certify that I attended the deceased from Sept 1938
1938 to March 1 1940
that I last saw him alive on Feb. 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 1/2 wks.

Due to Hypertension

Due to _____

Other conditions myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

3-10 (Specify type of place) (e) Means of injury _____

23. Signature Joseph B O'Neil (M. D. or other) _____
Address Clinton, mo. Date signed 3-2-40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11082

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community years, months or days

3. (a) PRINT FULL NAME

Julia H. Crome

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wed

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years 81 Months 9 Days 0

If less than one day hr. min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(b) Date thereof

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

3-9-40 (Date received local registrar)

(b)

Joseph R. Hampton (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Clinton
(If outside city or town limits write "RURAL")
(d) Street No. 305 South Second
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 1
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h. alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury
23. Signature Joseph B. Brail (M. D. or other)
Address Clinton Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1940

S-11082