

FILED JAN 12 1945  
Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 213

1. PLACE OF DEATH:

(a) County HENRY  
(b) City or town CLINTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: HENRY CO. JAIL. 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution NONE (Specify whether)  
In this community 16 DAYS.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_ 4-3  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. Clinton (Specify location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7  
year 1944 hour 12:30 minute 30

21. I hereby certify that I attended the deceased from Nov 7 1944 to Dec 6 1944

that I last saw him alive on Dec 6 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Gastritis Duration \_\_\_\_\_

Due to Morphine

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Major findings: Of operations None

Of autopsy None

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 J. B. Hampton (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 2-7-44

3. (a) PRINT FULL NAME CLARENCE CRENSHAW

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

4. Sex MALE 5. Color or race W. 6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased UNKNOWN (Month) (Day) (Year)

8. AGE: Years about 49 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace INDEPENDENCE MO (City, town, or county) (State or foreign country)

10. Usual occupation unknown

11. Industry or business \_\_\_\_\_

12. Name unknown

13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant: J. D. Tracy - Sheriff

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 12-8-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood Care

18. (a) Signature of general director A. G. Jansant

(b) Address Clinton, Mo

19. December 7, 1944 Georgia Ketcher (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED

District Health Officer No. 7,

District Number 12-44-1469

Date Filed 1-9-45

**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

*H. J. Vansant*

Licensed Embalmer No.

3779

P. O. Address

*Clinton*

**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, fact should be so stated above.**

State File No. \_\_\_\_\_

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 213

1. PLACE OF DEATH:

(a) County Henry Clinton  
(b) City or town \_\_\_\_\_  
(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)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Clarence Crenshaw

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 49 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Gastritis Duration \_\_\_\_\_

Due to morphine

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) no

(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 J.R. Hampton (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

4/273

4/273