

FILED JAN 17 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 926

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clinton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Shawnee</u>	
c. LENGTH OF STAY (in this place) <u>8 da.</u>		d. STREET ADDRESS (If rural, give location) <u>14 mi S + W of Shawnee Mound</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clinton General Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>HARVEY</u>	b. (Middle) <u>ALLEN</u>	c. (Last) <u>CROOKS</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>JAN 11 1950</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 10. 1869</u>	9. AGE (in years last birthday) <u>80</u>	10. UNDER 1 YEAR Months <u>10</u> Days <u>1</u>	11. UNDER 12 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Shawnee Mound Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Francis Crooks</u>	13b. MOTHER'S MAIDEN NAME <u>Marjette Thresher</u>	14. NAME OF HUSBAND OR WIFE <u>Anna May Crooks (deceased)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Sam. Pickering Chilhouse Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Influenzal pneumonia</u>		<u>10 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Influenza</u>		<u>12 days</u>
	DUE TO (c)		<u>480X</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic myocarditis</u>			<u>5 yrs.</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 2, 1950, to Jan 11, 1950, that I last saw the deceased alive on Jan 11, 1950, and the death occurred at 5:45 m., from the causes and on the date stated above.

23a. SIGNATURE (Print or Title) <u>James O. Smith M.D.</u>	23b. ADDRESS <u>Clinton, Missouri</u>	23c. DATE SIGNED <u>Jan 12, 1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 13-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shawnee Mound Bur.</u>	24d. LOCATION (City, town, or county) (State) <u>Henry Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Jan 13-50</u>	REGISTRAR'S SIGNATURE <u>Florence Adair</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Frederick Pickering Chilhouse Clinton Mo</u>
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
District Health Officer No. 7,  
District File Number 12-49-1589  
Date Filed 1-16-50

MAR 15 1950

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed .....  
Student Embalmer

Signed *Paul E. ...*

Licensed Embalmer No. 4510

P. O. Address Clinton, 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 this body is not embalmed, fact should be so stated above.