

RECEIVED

District Health Officer No. 4
District File Number 244-3315
Date Filed 2-7-44

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 Everett Sparks

Licensed Embalmer No. 4287

P. O. Address Flat River 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb.

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

1. PLACE OF DEATH:
 (a) County St. Francois
 (b) City or town Rural, St. Francois Jasp
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francois Co. Infirmary
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 mo.
(Specify whether)
 In this community Life
years, months or days

3. (a) PRINT FULL NAME Joseph Crump
 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 w
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct.
(Month) (Day) (Year)
 8. AGE: Years 84 Months 3 Days 15
If less than one day _____ min.

9. Birthplace Mo
(City, town, or county) (State or foreign country)
 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) Jan. 7 - 1944 (b) Byndie Buhmester
(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 Dec day 24
 year 1943 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 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 _____

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 _____

Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTAL

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

4158