V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 17 1943

Registration District No. 3318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29836

Primary Registration District No. 1003

Registrar's No. 8039

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Pacific Hospital (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)

2. USUAL RESIDENCE OF DECEASED: 94

(a) State Missouri (b) County St. Francois

(c) City or town Bonne Terre 2 (If outside city or town limits, write "RURAL") / NR

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME William Cruncleton Sr

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Anna Cruncleton

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Dec (Month) (Day) 1864 (Year)

8. AGE: Years 78 Months 89 Days 7

If less than one day hr. min.

9. Birthplace St. Francois County (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Retired Car-man

11. Industry or business Railroad

FATHER

12. Name WILLIAM Cruncleton

13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

MOTHER

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs Mable Sullivan

(b) Address 5709 Milentz

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/43 (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre, Mo.

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Blvd.

19. (a) SEP 9 1943 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8

year 1943 hour 1 minute 55 A M.

21. I hereby certify that I attended the deceased from 8-8-43, 19..., to 9-8, 19 43

that I last saw h... alive on 9-8, 19 43

and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Recurrent Ca. of Sigmoid

Due to Chronic myocarditis

Due to Senility

Due to

Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) MD

Address [illegible] Date signed 9-8-43

(Licensed Embalmer's Statement on Reverse Side)

OCT 18 1943

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 Albert N. Hopper

Licensed Embalmer No. 1861

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, fact should be so stated above.