

S. No. 2
-11-10-39
-5-17-39
-PI X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15264

State File No. 6

1940 MAY 8 1940 29
Registration District No. 5385

Primary Registration District No. 5385

Registrar's No. _____

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

1. PLACE OF DEATH: Johnson Co
(a) County: Johnson Co
(b) City or town: Rural, Groveport
(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: 0
In this community: Life
years, months or days: _____ (Specify whether)

3. (a) PRINT FULL NAME: AMANDA C. CRAWFORD
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: 616

4. Sex: Female 5. Color or race: White
6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife: O. S. Crawford
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: DEC 23, 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 1
If less than one day _____ hr. _____ min.

9. Birthplace: Pettis Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: at home

11. Industry or business: House Keeping

MOTHER FATHER
12. Name: John Fisher
13. Birthplace: Pettis Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name: Matilda
15. Birthplace: not known
(City, town, or county) (State or foreign country)

16. (a) Informant: O. S. Crawford
(b) Address: Houstonia, Mo

17. (a) Burial (b) Date thereof: 4, 25, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Grave

18. (a) Signature of funeral director: R. C. Carter
(b) Address: Sweet Springs Mo

19. (a) _____ (b) J. R. Roch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Pettis
(c) City or town: Sweet Springs
(If outside city or town limits, write "RURAL")
(d) Street No.: South of Sweet Springs
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1940 hour 2 minute 10 A. M.
21. I hereby certify that I attended the deceased from April 16
1940 to 4-23, 1940
that I last saw her alive on 4-23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial infarction, Chronic Myocarditis

Due to: Renal insufficiency
Due to: marked obesity

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: _____
PHYSICIAN: H. J. C.
Underlines 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?
380

While at work? _____ (Specify type of place)
(e) Means of injury: _____

23. Signature: Chas B Parson (M. D. or other) MD
Address: Sweet Springs Date signed: 4-24-40

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5-3-40

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..... *R. C. Carter*.....

Licensed Embalmer No. *3513*.....

P. O. Address..... *Street Long My*.....

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.