

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 144

Primary Registration District No. 5229

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Cedar
 (b) City or town Jarvis Spgs, Rural Benton
(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 2
(Specify whether years, months or days)
 In this community Most of life

3. (a) PRINT FULL NAME J. Tom Crawford 616
 8. (b) If veteran, name war _____ 8. (c) Social Security No. none

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
 6. (b) Name of husband or wife Martha Crawford 6. (c) Age of husband or wife if alive 83 years
 7. Birth date of deceased Nov. 15, 1957
(Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____
 MOTHER FATHER { 12. Name William Crawford
 13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)
 14. Maiden name UNKNOWN
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. Stackpole
 (b) Address El Dorado Spgs. Mo.
 17. (a) Burial (b) Date thereof 8-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Spur Ridge
 18. (a) Signature of funeral director H. C. Nash & Co.
 (b) Address Stockton Mo.
 19. (a) Aug - 17 - 40 (b) Wm May Heifner
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month August day 13
 year 1940 hour 2 minute P. M.
 21. I hereby certify that I attended the deceased from July 15, 1940 to Aug 13, 1940
 that I last saw him alive on Aug 11, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis
 Duration _____
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) 131

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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?
155 While at work? _____
(Specify type of place) (e) Means of injury
 23. Signature J. H. Dawson (M. D. certifier)
 Address El Dorado Spgs Date signed 8/16/40

RECEIVED

District Health Officer No. 7;

District File Number

9-40-1239

Date filed

9-4-40

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.....

Licensed Embalmer No.....

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28229

Registration District No. 164

Primary Registration District No. 5229

Registrar's No.

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town Benton
(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 Jefferson Thomas Crawford

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 m

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive year

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

8. AGE: Years 82 Months 8 Days 28 If less than one day hr. min.

9. Birthplace: (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Aug-17-1940 (b) Mr. May Helmer (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) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug day 13 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw h. alive on 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

23. Signature J. W. Dawson (M. D. or other)

Address Eldorado Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY