

Registration District No. 768

Primary Registration District No. 5629

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Logan
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether years, months or days) 84 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Logan MO
(If outside city or town limits, write "RURAL") 5500
(d) Street No. CITY (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Sarah D. Crawford

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife R. P. Crawford 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased OCT 10 1856
(Month) (Day) (Year)

8. AGE: Years 84 ✓ Months 3 Days 12 If less than one day hr. min.

9. Birthplace BARRY COUNTY MO
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Ben Kennedy

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

14. Maiden name UNKNOWN

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

16. (a) Informant Mrs. Flora Lett

(b) Address Logan MO

17. (a) Burial (b) Date thereof Jan 22 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Avoca MO

18. (a) Signature of funeral director Oscar H. Mark

(b) Address 229 W. Church St. Avoca MO

19. (a) Jan 22 1941 (b) Laura C. Cannady
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan, day 22
year 1941, hour One minute 30 A. M.

21. I hereby certify that I attended the deceased from August 22, 1941, to Jan 22, 1941, that I last saw her alive on Jan 21, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis, 1 yr.

Due to g2w
Other conditions (Include pregnancy within 3 months of death)

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?
While at work? (Specify type of place) (e) Means of injury
23. Signature Dr. Wayne M. Weaver (M. D. or other)
Address Marionville, Mo. Date signed 1/22/41

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

RECEIVED

District Health Officer No. 6.

District File Number

Date Filed **FEB 7 1941**

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.....

Myself
....., Registered Apprentice No. *None*
working under my personal supervision.

Signed.....

Oliver L. Marsh
.....
Licensed Embalmer No. *3872*

P. O. Address *From me*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3189

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 468

Primary Registration District No. 5629

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laurens
(b) City or town Buck Prairie T.P.
(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 Sarah D. Crawford

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____ years

7. Birth date of deceased Oct 10 1856
(Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days 12 If less than one day _____ 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) _____ (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) Apr 5, 1941 (b) Laura C. Connolly
(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 Jan day 22
year 1941 hour _____ minute _____ M.

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

23. Signature Wayne M. Weaver (M. D. or other) _____

Address Marionville Mo. 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

