

FILED APR 21 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

11512

Do not use this space.

## 1. PLACE OF DEATH

(a) County Madaway Registration District No. 624  
 (b) Township Hopkins Primary Registration District No. 4375  
 (c) City Hopkins (d) Street No. 1 St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Robert Marion Crawford  
 (a) Residence, No. Not in U.S. St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 24 - 1940

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
6 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MT AIR IOWA

FATHER 13. NAME JAMES CRAWFORD

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KADOKA S. DAK. I

MOTHER 15. MAIDEN NAME FRANCES RUNYAN

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MASON CITY NEBR I

17. INFORMANT (ADDRESS) James Crawford Hopkins Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mitchellville, Ia DATE Mar. 8, 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley Swanson Hopkins Mo

20. FILED M 1, 41 1941 O.H. Taylor Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6, 1941

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 11:15 a.m., 1941

The principal cause of death and related causes of importance were as follows:

Pneumonia  
Pulmonary edema with  
Cardiac Collapse

Date of onset

Other contributory causes of importance:  
From history it appears child had some thymic bleedings the last 3 months of life.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Cervical Angiogram Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence) fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) W.P. Jackson M. D.  
 (Address) Marquette, Mo.

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STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES

**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, myself, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Stanley Swanson

Licensed Embalmer No. 3963

P. O. Address Hopkins, 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, above space should be left blank.**

MISSISSIPPI DEPARTMENT OF HEALTH BUREAU OF HEALTH SERVICES

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 115-12  
Registrar's No. \_\_\_\_\_

Registration District No. 624

Primary Registration District No. 4875

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

1. PLACE OF DEATH:

(c) County Wodaway  
(b) City or town Hopkins  
(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 Robert Marion 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 s  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 24 \_\_\_\_\_ 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) \_\_\_\_\_ (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) 6/9/41 (b) O. H. Saylor  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wodaway  
(c) City or town Hopkins  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 6  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive or \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. L. Jackson (M. D. or other) \_\_\_\_\_

Address Marionville Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

11512

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**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11572

Registration District No. 624

Primary Registration District No. 4375

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Madison
  - (b) City or town Wapakoneta  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Robert Marion 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

8

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

Months

Days

If less than one day

6

12

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)

(Date received local registrar)

(b)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 6  
year 1947 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 Pneumonia Duration \_\_\_\_\_  
Pulmonary edema  
Cardiac collapse  
Due to \_\_\_\_\_

Other conditions from history it appears  
(Include pregnancy within 3 months of death)  
Child had some thyroid PHYSICIAN  
Major findings: depressed, the rat and  
Of operations 3 1/2 months of life  
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 W. E. Jackson (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER