

S. No. 2  
M-5-43  
7-5-17-39  
P I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18582  
Registrar's No. 52

FILED JUN 12 1944  
Registration District No. 1037

Primary Registration District No. 3041

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

1. PLACE OF DEATH:  
(a) County Macon  
(b) City or town Macon  
(c) Name of hospital or institution: Samaritan Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Days  
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Macon  
(c) City or town Clarence Rural  
(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 AARON Bowman Crawford  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Nora Crawford  
6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased August 15th 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 8 22 hr. min.

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

10. Usual occupation Farming  
11. Industry or business Same

12. Name James J. Crawford  
13. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Bowman  
15. Birthplace Tennessee  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nora Crawford  
(b) Address Clarence Mo

17. (a) Burial (b) Date thereof 5/9/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarence Mo  
18. (a) Signature of funeral director William B. Burkholder  
(b) Address Clarence Mo  
19. (a) 6/2/44 (b) Nora B. Burkholder  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7th  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 5-5-1944  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on 5-6-1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Due to Cardio-vascular disease  
Due to \_\_\_\_\_

Duration  
10 days  
10 more yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: 938  
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. B. Burkholder (M. D. or other) \_\_\_\_\_  
Address Clarence Mo Date signed 6-3-44

RECEIVED  
District Health Officer No. 10  
District File Number 6-44-1097  
Date Filed JUN 9 1944

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 Henry G. Barkley  
Licensed Embalmer No. 3835  
P. O. Address Helena - 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, fact should be so stated above.**