

FILED SEP 30 1944

Registration District No. 818

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County ~~St. Louis~~

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Masonic Home of Missouri  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 mos  
(Specify whether years, months or days)

In this community 2  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James Hamilton Crawford

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alta

6. (c) Age of husband or wife if alive 686 years

7. Birth date of deceased October 6, 1855  
(Month) (Day) (Year)

8. AGE:

| Years     | Months    | Days      | If less than one day |
|-----------|-----------|-----------|----------------------|
| <u>88</u> | <u>11</u> | <u>11</u> | _____hr. _____min.   |

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

10. Usual occupation Grocery

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name James Crawford

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

14. Maiden name Susan Green Tadlock

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Iva Furch

(b) Address 5351 Delmar

17. (a) Burial (b) Date thereof 9-30-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 18 1944 (b) J. P. Redel  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~St. Louis~~

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5351 Delmar Blvd  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17  
year 1944 hour 805 minute A M.

21. I hereby certify that I attended the deceased from December 21, 1943 to Sept 17, 1944  
that I last saw him alive on Sept 16, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Sinility Duration 6 months

Due to Chronic Myocarditis 9 months

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)

(c) Means of injury \_\_\_\_\_

23. Signature Alton Hamilton (M. D. or other) \_\_\_\_\_  
Address 508 1/2 Grand Blvd Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

.....  
working under my personal supervision.

..... Registered Apprentice No. ....

Signed.....

*Albert G. Hoppe*

..... Licensed Embalmer No. ....

*2921*

..... 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.**