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M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24435**

FILED AUG 2 1945

Registration District No. **227**

Primary Registration District No. **4315**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **MACON**

(b) City or town **LAPLATA**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **89 years** (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ADAIR**

(c) City or town **GIBBS**
(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 _____

3. (a) PRINT FULL NAME **NANCY VELMA CRAWFORD**

3. (b) If veteran, name war **✓**

3. (c) Social Security No. **NONE**

4. Sex **F** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **DANIEL H. CRAWFORD**

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

7. Birth date of deceased: **APRIL 29 1853**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

92 2 20 hr. min.

9. Birthplace **PUSHVILLE ILLINOIS**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

12. Name **MICHAEL STANFORD**

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

14. Maiden name **MATILDA HIMER**

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

16. (a) Informant **Miss J. N. Garlock**

(b) Address **7-28-46 Gibbs Mo.**

17. (a) **BURIAL** (b) Date thereof **7-22-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Union Cemetery**

18. (a) Signature of funeral director **Foster R. Easley**

(b) Address **Prochean Mo.**

19. (a) **7-28-46** (b) **H. M. Ross**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **19**
year **1945** hour **5** minute **0** P. M.

21. I hereby certify that I attended the deceased from **July 18 1945** to **July 18 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic endocarditis**

Due to: **Arteriosclerosis**

Due to: **Senility**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **920**

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 **Foster R. Easley** (M. D. or other) **AD**
Address **Laplata Mo.** Date signed **7/24/45**

Duration **probably years**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1390

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 7-45-1202

Date Filed AUG 1 1945

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.....

Geo B Easley

Licensed Embalmer No. 3755

P. O. Address.....

Turdland 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.