

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 365

Primary Registration District No. 4534

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Caledonia  
(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 two years  
In this community two years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington

(c) City or town Caledonia  
(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 Glen Crawford

3. (b) If veteran, name war World War 1

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 Pearl Crawford

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased May 16th 1897  
(Month) (Day) (Year)

8. AGE: Years 49 Months 2 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

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

MOTHER FATHER

12. Name Unknown Geo. Crawford

13. Birthplace Unknown St. Louis Mo.  
(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. Pearl Crawford

(b) Address Caledonia Missouri

17. (a) burial (b) Date thereof 7-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Missouri

19. (a) 8-24-46 (b) Ella White  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18  
year 1946 hour 4:30 minute 7 M.

21. I hereby certify that I attended the deceased from July 18 1946 to July 18 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Heart Stroke

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 197

Of autopsy 20

Duration \_\_\_\_\_

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 Has W. Buff man (M. D. or other) MD

Address Bismarck Mo Date signed 7-25-46

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

RECEIVED

Sanitary Health Officer No. 4  
Sanitary File Number 846-2520  
Date Filed 8-21-46

SEP 11 1946

OCT 4 1946

---

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 Arnel J. White  
Licensed Embalmer No. 3012  
P. O. Address Fronton, Va.

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.