

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 31 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 326

Primary Registration District No. 6110

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Scotland

(b) City or town Burd  
(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 \_\_\_\_\_ (Specify whether years, months or days) All her life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scotland

(c) City or town Burd  
(If outside city or town limits, write "RURAL")

(d) Street No. 17th West of Crawford  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Maggie Crawford

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17 year 1947 hour 12 minute 10 AM.

21. I hereby certify that I attended the deceased from 2/21 1947 to 3/15 1947 that I last saw her alive on 2/26 1947 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife James B Crawford 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 12 1866  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage and acute hepatitis

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

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

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

8. AGE: Years 80 Months 5 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired Housewife

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

MOTHER FATHER

12. Name Stratton McCary

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

14. Maiden name Hilda Benning

15. Birthplace Dont know  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. William Krosson

(b) Address Memphis Mo

17. (a) Burial (b) Date thereof Mar 18 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friendship

18. (a) Signature of funeral director Smith & Barber

(b) Address Memphis Mo

19. March 19-47 (b) Mrs. E. E. Parrel  
(Date received local registrar) (Registrar's signature)

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 OTM Baker (M. D. or other) \_\_\_\_\_

Address Memphis Date signed 3/18/47

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

99  
03

RECEIVED  
District Health Officer No. 10  
District File Number 3-47-591  
Filed MAR 28 1947

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. 4258  
P. O. Address Memphis TN

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.