S. No. 2
I—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 4 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23257

Registration District No. 2 | Primary Registration District No. 2018 | Registrar's No. 183

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

2 0 0

1. PLACE OF DEATH:

(a) County: Andrew

(b) City or town: Rural – Platte Twp.
(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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Andrew 2

(c) City or town: Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Phyllis Jean Crawford

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: female

5. Color or race: W

6. (a) Single, widowed, married, divorced: —

6. (b) Name of husband or wife: —

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

7. Birth date of deceased: July (Month) 23 (Day) 1947 (Year)

8. AGE: Years | Months | Days | If less than one day: 11 hr. 30 min.

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

10. Usual occupation: —

11. Industry or business: —

MOTHER FATHER

12. Name: Charles W. Crawford

13. Birthplace: Andrew Co. (City, town, or county) Mo. (State or foreign country)

14. Maiden name: Thelma M. Hephart

15. Birthplace: Winterset (City, town, or county) Ia. (State or foreign country)

16. (a) Informant: Charles H. Crawford

(b) Address: Bolckow, Mo.

17. (a) B (Burial, cremation, or removal) (b) Date thereof: 7-26-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Whitesville

18. (a) Signature of funeral director: E. B. Frech

(b) Address: Savannah, Mo.

19. (a) 7-26-47 (Date received local registrar) (b) Lillian Spark (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1947 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 23, 1947 to July 24, 1947 that I last saw her alive on July 23, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Immaturity of Respiratory Center	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature: W. B. Maxwell (M. D. or other) D.O.

Address: Savannah, Mo. Date signed 7/26/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Di[illegible]

Cameron, Mo.

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. 3, working under my personal supervision.

Signed E. E. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.