

FILED JUN 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19161

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>530</u>		
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>7 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>827 East Normal</u>				d. STREET ADDRESS (If rural, give location) <u>827 East Normal</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u>		b. (Middle) <u>C</u>		c. (Last) <u>Crighton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 14 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 17, 1863</u>		
9. AGE (in years last birthday) <u>85</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Dundee, Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Crighton</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Campbell</u>			14. NAME OF HUSBAND OR WIFE <u>Florence Jackson Crighton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>W T Crighton, Springfield, Missouri</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis cerebral & cardiac</u>					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					<u>234X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from _____, 1947, to <u>June 14, 1949</u> , that I last saw the deceased alive on <u>June 12, 1949</u> and that death occurred at <u>6:45 P.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>W. H. Hunsawer M.D.</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>6-15-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 16, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>6-16-49</u>		REGISTRAR'S SIGNATURE <u>W. E. Hunsawer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeyer</u>		ADDRESS <u>J. H. Springfield, Mo.</u>		

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Jewell E. Kinde

Signed _____
Student Embalmer

Licensed Embalmer No. 2831

P. O. Address Springfield

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.