

FILED JUN 12 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19112

State File No.

BIRTH NO. _____ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 307 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>	
c. LENGTH OF STAY (In this place) <u>30 years</u>		d. STREET ADDRESS (If rural, give location) <u>819 N Elm St</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Slater</u>		e. FULL NAME OF HOSPITAL OR INSTITUTION <u>Slater</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>FRANKLIN</u> c. (Last) <u>CRAWFORD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 4-1951</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>January 30-1886</u>
9. AGE (In years last birthday) <u>65-44</u>	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired RR Conductor</u>	11. BIRTHPLACE (State or foreign country) <u>Mexico Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE	12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Thomas Crawford</u>	13b. MOTHER'S MAIDEN NAME <u>Hattie Whittman</u>	14. NAME OF HUSBAND OR WIFE <u>Mabel Lucille Crawford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war) <u>No</u> (Date of service)	16. SOCIAL SECURITY NO. <u>70942-0093</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mabel Lucille Crawford</u> ADDRESS <u>Slater Mo</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>Coronary thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) <u>Peters Pileuriosis</u> DUE TO (c) <u>Myocardium</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u> <u>4 to 5 yrs</u>	
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>7-8</u> , 19 <u>50</u> to <u>June 3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>51</u> , and that death occurred at <u>4:15</u> p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>W. E. Robertson</u>		23b. ADDRESS <u>Slater Mo</u>	23c. DATE SIGNED <u>6-5-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June-6-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Slater City Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Slater Mo</u>
DATE REC'D BY LOCAL REG. <u>6-6-51</u>	REGISTRAR'S SIGNATURE <u>Ms. Earl C. King</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Salzer</u> ADDRESS <u>Slater Mo</u>	

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

971

RECEIVED 6-11-51

DISTRICT HEALTH OFFICE NO. 1

District File Number

Date Filed 6-11-51

1957 F. F. 7191

MAY 24 1955

AUG 19 1955

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.

Student _____
Student Embalmer

Signed

James E Jones

Licensed Embalmer No. 3143

P. O. Address *Slater, 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.