U.S. No. 300
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39

BIRTH NO. _____ REG. DIST. NO. #2 PRIMARY REG. DIST. NO. 5017 Registrar's No. 3

0020
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY: Andrew
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural near Savannah
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shady Lawn Nursing home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Andrew
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural near Savannah mo
d. STREET ADDRESS (If rural, give location): 0020

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle):
c. (Last): Crawford

4. DATE OF DEATH (Month) 1 (Day) 5 (Year) 1953

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: 2-10-1878
9. AGE (In years last birthday): 74 — If under 1 year: Months 10, Days 25 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jewelray Repair man
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Jefferson co Ind
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Add Crawford
13b. MOTHER'S MAIDEN NAME: Babria Carley
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 491-281-1448
17. INFORMANT'S SIGNATURE OR NAME: Raymond Crawford Rea. ADDRESS: mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardio Vascular - Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arterio-sclerosis — 10 yrs.
DUE TO (c): 4500

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1948, *to* Dec., 1952, *that I last saw the deceased alive on* Dec, 1952, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gilbert B. Kellington
23b. ADDRESS: Savannah, Mo.
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-8-53
24c. NAME OF CEMETERY OR CREMATORY: Whitesville
24d. LOCATION (City, town, or county) (State): Whitesville mo

DATE REC'D BY LOCAL REG.: 1-10-53
REGISTRAR'S SIGNATURE: Lillian Sparks 2-0
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Breit Funeral Home Savannah mo

(Licensed Embalmer's Statement on Reverse Side)

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Sarcoxie 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.