

FILED JUN 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18570

573

|   |   |  |   |  |  |   |  |   |
|---|---|--|---|--|--|---|--|---|
| BIRTH NO. _____   |   | REG. DIST. NO. <u>128</u>  |   | PRIMARY REG. DIST. NO. <u>2000</u>   |  | Registrar's No. _____   |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> |  |   |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>   |   | c. LENGTH OF STAY (In this place)  |   | c. CITY OR TOWN <u>Springfield</u>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St. Johns Hospital</u>  |   |  |   | e. STREET ADDRESS (If rural, give location) <u>215 E. Sunshine</u> <span style="float: right;">03960</span>                            |  |   |  |   |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>ANNIE</u>  |   |  | b. (Middle) <u>P.</u>                                       |  | c. (Last) <u>CRAIN</u>   |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>June 15, 1954</u> |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>                                  |   | 8. DATE OF BIRTH <u>7 July 1875</u>  |  | 9. AGE (In years last birthday) <u>78</u>   | IF UNDER 1 YEAR: Months _____ Days _____                   | IF UNDER 10 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>In Home</u>   |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |   |
| 13a. FATHER'S NAME <u>Robert J. Lawing</u>  |   |  | 13b. MOTHER'S MAIDEN NAME <u>Mary Clark</u>                 |  | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u>  |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>No</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ellen Clifton Springfield, Mo.</u>  |  |   |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                          | MEDICAL CERTIFICATION   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>           |   |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Pulmonary Edema</u>   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u> |  |   |  |  |   |  |   |
|   | DUE TO (c) _____  |  |   |  |  |   |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |   |  |  |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. MAJOR FINDINGS OF OPERATION <u>4200</u>   |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.  |   | 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 <u>6-15, 1954</u> , to <u>6-15, 1954</u> , that I last saw the deceased alive on <u>6-15, 1954</u> , and that death occurred at <u>9:15 p.m.</u> , from the causes and on the date stated above. |   |  |   |  |  |   |  |   |
| 23a. SIGNATURE <u>Harold H. Lurie, M.D.</u> (Degree or title)   |   |  |   | 23b. ADDRESS <u>609 Cherry Springfield, Missouri</u>   |  | 23c. DATE SIGNED <u>6-17-54</u>   |  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |   | 24b. DATE <u>6-17-54</u>   | 24c. NAME OF CEMETERY OR CREMATORY <u>Eastlawn Cemetery</u> |  | 24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>             |   |  |   |
| DATE REC'D BY LOCAL REG. <u>6-18-54</u>   |   | REGISTRAR'S SIGNATURE <u>Edith Williams</u>  |   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Klingner &amp; Co. Springfield, Mo.</u> |   |  |   |

(Licensed Embalmer's Statement on Reverse Side)

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..

Student.....  
Signature of Student Embalmer

Signed.....  
*Max A. Hood*

Licensed Embalmer No. ....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

X