

FILED OCT 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32767

BIRTH NO.		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 147	
1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Scott			
b. CITY (If outside corporate limits, write RURAL and give township) Sikeston,		c. LENGTH OF STAY (In this place) 18 days		c. CITY OR TOWN Sikeston		d. In 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 Mo. Delta Community Hospital				e. STREET ADDRESS (If rural, give location) 823 Ruth			
3. NAME OF DECEASED (Type or Print) Prentice		a. (First) E.		b. (Middle) Crawford		c. (Last) Crawford	
4. DATE OF DEATH (Month) (Day) (Year) 10-4-1954		5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH (Specify) 3-25-1897		9. AGE (In years last birthday) 53		IF UNDER 1 YEAR Months 6 Days 9		IF UNDER 1 Wks. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled veteran		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (City and State or Foreign Country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Chap Crawford		13b. MOTHER'S MAIDEN NAME Louiza Morrison		14. NAME OF HUSBAND OR WIFE Ada Crawford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. --		17. INFORMANT'S SIGNATURE OR NAME Ada Crawford Sikeston, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) XXXXXXXXXX		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 9-16, 1954, to 10-4, 1954, that I last saw the deceased alive on 10-4, 1954, and that death occurred at 9:47 Am., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Alden Sargent MD				23b. ADDRESS 707 Tanner, Sikeston, Mo.		23c. DATE SIGNED 10-4-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 10-6-54		24c. NAME OF CEMETERY OR CREMATORY NEW HOPE		24d. LOCATION (City, town, or county) (State) POLLARD ARK.	
DATE REC'D BY LOCAL REG. 10-5-54		REGISTRAR'S SIGNATURE Miss Ella Hunter 429		25. FUNERAL DIRECTOR'S SIGNATURE Welch Funeral Home - Sikeston Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-481003
0

DATE RECEIVED OCT 11 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1054-210

OCT 19 1954

OCT 15 1954

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 Raymond Crews

Licensed Embalmer No. 3467

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