

FILED FEB 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 384
 BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>Callaway</u> <u>2</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scotland</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton, Mo.</u>		c. CITY OR TOWN <u>Memphis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>23 yrs lmo</u>		e. STREET ADDRESS (If rural, give location) <u>none</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>State Hospital #1, Fulton, Mo.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>E. H.</u> b. (Middle) <u>H.</u> c. (Last) <u>Crawford</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 11, 1955</u>
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5. SEX <u>Male</u> <u>0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1881</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 14 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Do not know</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Do not know</u>	13b. MOTHER'S MAIDEN NAME <u>Do not know</u>	14. NAME OF HUSBAND OR WIFE <u>Nora Crawford</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>D.K.</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records of State Hospital #1, Fulton, Mo.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH years _____
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>		
	ANTECEDENT CAUSES Morbidity 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.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Memphis Missouri</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Sep. 17, 1953, to Feb. 11, 1955, that I last saw the deceased alive on 2-11-55, 1955, and that death occurred at 6:00P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Frank J. Nichols M.D.</u> (Doctor or title)	23b. ADDRESS <u>State Hospital #1, Fulton, Mo.</u>	23c. DATE SIGNED <u>2-11-1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Feb 12 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>DK</u>	24d. LOCATION (City, town, or county) (State) <u>Memphis Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Feb. 12 - 1955</u>	REGISTRAR'S SIGNATURE <u>Martha Lawrence</u> <u>456-0</u>	FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Maupin Funeral Home Fulton Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 *Gay W. Stewart*

Licensed Embalmer No. *377*

P. O. Address *Fulton*

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.