

No. 300  
10.46

FILED MAR 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10793**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6225** Registrar's No. **24**

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Hickory</b>	
b. CITY (If outside corporate limits, write R.U.B.A. and give township) <b>Washington Twp.</b>	c. LENGTH OF STAY (In this place) <b>2-2-2</b>	c. CITY OR TOWN <b>Cross Timbers</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital #3</b>		e. STREET ADDRESS (If rural, give location) <b>Rural 04501</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Mary</b>	b. (Middle) <b>Viola</b>	c. (Last) <b>Crawford</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>3-21-55</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>	8. DATE OF BIRTH <b>2-9-1876</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Hickory County Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Brown</b>	13b. MOTHER'S MAIDEN NAME <b>Sally Hoffman</b>	14. NAME OF HUSBAND <b>Unknown</b>
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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) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Alberta Mitchell</b>	ADDRESS <b>Preston Mo</b>
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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, asphemia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arterio Sclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs +</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.  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)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>4200</b>
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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?
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22. I hereby certify that I attended the deceased from **1-19-1953**, to **3-21-1955**, that I last saw the deceased alive on **3-21-1955**, and that death occurred at **5:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. B. Burch M.D.</b>	23b. ADDRESS <b>State Hospital #3</b>	23c. DATE SIGNED <b>3-21-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3-21-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Whitland Mo.</b>
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DATE REC'D BY LOCAL REG. <b>3-24-1955</b>	REGISTRAR'S SIGNATURE <b>Anna E. Ferrys</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Howe Funeral Service</b>	ADDRESS <b>Woods Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 *H. H. Marmaduke*

Licensed Embalmer No. *207*

P. O. Address *Aswada*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (If  
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.