

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1388

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Robertson</u>	c. LENGTH OF STAY (in this place) <u>18 Mos</u>	c. CITY OR TOWN <u>Robertson 4070</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Rt #3, Box 815</u>		e. STREET ADDRESS (If rural, give location) <u>Rt #3, Box 815</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>HARRIS</u>	b. (Middle) <u>H.</u>	c. (Last) <u>CRAWFORD</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 17, 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 7, 1912</u>	9. AGE (In years last birthday) <u>42</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Lincoln-Mercury</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Myrtle, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles A. Crawford</u>	13b. MOTHER'S MAIDEN NAME <u>Josie Ann Brewer</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth (Mulkey) 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>No</u>	16. SOCIAL SECURITY NO. <u>363-05-0533</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Ruth Crawford, Robertson, 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 <u>2 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>		
	ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
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) <u>4201</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 8-27, 1954 to 6-17, 1955, that I last saw the deceased alive on 6-17, 1955, and that death occurred at 11 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Halvor S. Nelson M.D.</u>	23b. ADDRESS <u>Ferguson, Mo.</u>	23c. DATE SIGNED <u>6-18-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>6-22-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Thayer Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Thayer, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>6/19/55</u>	REGISTRAR'S SIGNATURE <u>Kerbert R. Domke, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Carter Funeral Home, Thayer, Mo.</u>
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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 *Eleanora Province*.....

Licensed Embalmer No. 3403.....

P. O. Address Jennings, Mi.....

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.