

FILED NOV 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32255

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1155

1. PLACE OF DEATH a. COUNTY <b>Richanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mercer</b>		
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Joseph</b>		c. LENGTH OF STAY (In this place) <b>3 Wks</b>	c. CITY OR TOWN <b>Cainsville</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>Missouri Methodist Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>R.F.D. # 1</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frank</b> b. (Middle) <b>E.</b> c. (Last) <b>Crawford</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>October 24-1955</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 4th 1869</b>	9. AGE (In years last birthday) <b>86 Yrs</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired:</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Mercer County, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Tom J. Crawford</b>		13b. MOTHER'S MAIDEN NAME <b>Charlotta Jane Dunn</b>		14. NAME OF HUSBAND OR WIFE <b>Dell Crawford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Dell Crawford, R.F.D. # 1 Cainsville Mo.</b>		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic heart disease</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio sclerosis</b> DUE TO (c) <b>4900</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>10 yrs.</b>
19a. DATE OF OPERATION <b>10-1-55</b>	19b. MAJOR FINDINGS OF OPERATION <b>Benign prostatic hypertrophy</b>				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)	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 <b>10-1</b> 19 <b>55</b> , to <b>10-23</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>10-23</b> , 19 <b>55</b> , and that death occurred at <b>12:55am</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Robert B. Preston</b>			23b. ADDRESS <b>M.D. St. Joseph Mo</b>		23c. DATE SIGNED <b>10-24-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>(Removal)</b>	24b. DATE <b>Oct. 24-1955</b>	24c. NAME OF CEMETERY OR CREMATOR <b>Bethel Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Mercer, Missouri.</b>	
DATE REC'D BY LOCAL REG. <b>Nov 1, 1955</b>	REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>		495	25. FUNERAL DIRECTOR'S SIGNATURE <b>Blanche St. Joseph, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10. 48

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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 *Albert C. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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.