

FILED DEC 4 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37795

STATE FILE NUMBER

Registration District No. 139

Primary Registration District No. 4221

Registrar's No. 85

1. PLACE OF DEATH

a. COUNTY

Holt

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Holt

b. CITY (If outside corporate limits, give TOWNSHIP only)

Mound City

Inside Limits

Yes No

c. CITY

Mound City

Inside Limits

Yes No

c. FULL NAME OF (If NOT in hospital, give location)

Duncan Nursing Home 1 mon

Length of stay in 1b

d. STREET

99 A Street

(If outside, give location)

Reside on Farm

Yes No

3. NAME OF DECEASED (Type or print)

First

HELEN

Middle

LUCILLE

Last

CRAWFORD

4. DATE OF DEATH

Month

Day

Year

Nov. 28 1956

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 23, 1884

9. AGE (In years last birthday)

72

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

In the home

11. BIRTHPLACE (City and state or country)

Oneida, Kansas

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Caleb W. Harter

14. MOTHER'S MAIDEN NAME

Isabella Ashbrook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Eleanor Shipps, St. Joseph, Mo.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Occlusion

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour Month, Day, Year
a. m.
p. m.20d. INJURY OCCURRED
WHILE AT WORK NOT WHILE AT WORK

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 10-23-56 to 11-28-58 and last saw her/him alive on 11-27-56. Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

DB Perry, M.D. Mound City Mo

22b. ADDRESS

22c. DATE SIGNED

12-1-56

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

12/1/56

23c. NAME OF CEMETERY OR CREMATORY

Mount Hope Cemetery

23d. LOCATION (City, town, or county)

Mound City, Missouri

24. FUNERAL DIRECTOR

ADDRESS

James H. Pettigrew, M.D. Mound City, Mo.

25. DATE RECD. BY LOCAL REG.

12-1-1956

26. REGISTRAR'S SIGNATURE

James H. Crawford

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

1957 FEB 14

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 *James H. Pettigrew*
Licensed Embalmer No. *319*
P. O. Address *Oregon*

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.