

health, Welfare public service
 300
 1-56
 ALL diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 50

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

40599

STATE FILE NUMBER

FILED DEC 17 1956

Registration District No.

42

Primary Registration District No.

1000

Registrar's No.

1301

1. PLACE OF DEATH a. COUNTY Buchanan				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) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Mound City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.			Length of stay in 1b 2 days	d. STREET ADDRESS 99 A Street			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last CRAWFORD				4. DATE OF DEATH Dec. 5, 1956 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1878		9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furn. Dir. & Und.		10b. KIND OF BUSINESS OR INDUSTRY Furn. & Und.		11. BIRTHPLACE (City and state or country) Nevinville, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hamilton Crawford				14. MOTHER'S MAIDEN NAME Elizabeth Niles			
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. 500-36-1637		17. INFORMANT James H. Crawford, Mound City, Mo. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Acute coronary occlusion DUE TO (c) 420.1						INTERVAL BETWEEN ONSET AND DEATH 80 min 70 min	
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 <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 Dec 3, 56 to Dec 5, 56 and last saw her alive on Dec 4, 56 Death occurred at 3:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) W. A. Rich M.D.				22b. ADDRESS St. Joseph, Mo		22c. DATE SIGNED 12-10-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-7-1956	23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		23d. LOCATION (City, town, or county) Mound City, Missouri		(State)
24. FUNERAL DIRECTOR W. A. Rich, Savannah, Mo.				25. DATE RECD. BY LOCAL REG. Dec 12, 1956		26. REGISTRAR'S SIGNATURE Kathleen M. Allison	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Wm Rieh*.....

Licensed Embalmer No. *42*

P. O. Address *Savannah*

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

Bristow