

Health,  
& Welfare  
Public  
Service

FILED MAY 27 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
**16159**

Registration District No. **38** Primary Registration District No. **3006** Registrar's No. **181**

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Stephens</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Boone County Hosp</b>			Length of stay in 1b		d. STREET ADDRESS <b>Route 1</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Virgil</b> Middle <b>Clarence</b> Last <b>Crisp</b>				4. DATE OF DEATH Month <b>5</b> Day <b>18</b> Year <b>1957</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9, 1903</b>		9. AGE (In years last birthday) <b>54</b> IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Manes, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John F. Crisp</b>				14. MOTHER'S MAIDEN NAME <b>Betty McClanahan</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>-</b>		17. INFORMANT Address <b>Mrs. Virgil C. Crisp, Route 1, Stephens, Mo</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <b>Cor Pulmonale</b>		<b>1 year</b>	
							DUE TO (c) <b>Bronchiectasis</b>		<b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>526x</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>			
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 <b>11:15</b> Month <b>19</b> Day <b>19</b> Year <b>57</b> 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 <b>1 NOV 56</b> to <b>17 May 57</b> and last saw <del>him</del> <b>her</b> alive on <b>12 May 57</b> Death occurred at <b>11:15 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>Phyllis Logan MD</b> (Degree or title)				22b. ADDRESS <b>909 University Ave Columbia Mo</b>			22c. DATE SIGNED <b>18 May 57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
<b>Removal</b>		<b>May 19, 1957</b>		<b>Mt. Rose Cemetery</b>		<b>Lebanan, Missouri.</b>				
24. FUNERAL DIRECTOR <b>Parker Funeral Service, Columbia, Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>May 18 1957</b>		25. REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>				

S. 300  
Y. 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Raymond James* .....

Licensed Embalmer No. *5016*

P. O. Address *Columbia*

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.