

Health, Welfare and Public Service

DR. E. L. CLAYTON

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27994

STATE FILE NUMBER

FILED SEP 3 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 842

300
-57
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1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) 3029 W. Grand	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b hours		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JANIE Middle CORRINE Last CROWE			4. DATE OF DEATH Month August Day 26 Year 1957		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24, 1957	9. AGE (In years last birthday) FUNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours 35 Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Springfield, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Almus Wesley Crowe	13b. MOTHER'S MAIDEN NAME Delia Josephine Abbott	14. NAME OF HUSBAND OR WIFE -----
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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)	16. SOCIAL SECURITY NO. -----	17. INFORMANT Address Almus W. Crowe (Father) 3029 W. Grand
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
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 checked="" 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.)
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from Death occurred at 9:15 A on Aug 24 to Aug 26, 1957 and last saw her alive on Aug 15, 1957 m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Edgar L. Clayton M.D.	22b. ADDRESS Professional Bldg Springfield, Missouri	22c. DATE SIGNED 8-28-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Rem - Burial	23b. DATE 8-26-57	23c. NAME OF CEMETERY OR CREMATORY Bruner Cemetery	23d. LOCATION (City, town, or county) (State) Bruner, Missouri
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24. FUNERAL DIRECTOR T. B. Chaffin	ADDRESS Ozark, Mo	25. DATE RECD. BY LOCAL REG. 8-28-57	26. REGISTRAR'S SIGNATURE Edith Williamson
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *T. B. Chaffin*

Licensed Embalmer No. *2192*

P. O. Address *Ozark, 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.