

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31096**

FILED OCT 7 1957

BIRTH NO. _____ REG. DIST. NO. **55** PRIMARY REG. DIST. NO. **3011** Registrar's No. **89**

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Mo b. COUNTY CARROLL	
b. CITY OR TOWN CARROLLTON 4		c. CITY OR TOWN CARROLLTON	
d. FULL NAME OF HOSPITAL OR INSTITUTION BROCKMAN REST HOME		e. STREET ADDRESS (If rural, give location) 205 So. FOLGER	

3. NAME OF DECEASED a. (First) BERTHA b. (Middle) VIOA c. (Last) CRAWFORD			4. DATE OF DEATH (Month) (Day) (Year) SEPT. 28 1957		
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5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH NOV. 23 1881	9. AGE (In years last birthday) 76	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) NURSE	11. BIRTHPLACE (City and State or Foreign Country) KENTUCKY 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME L.P. HEADINGS		13b. MOTHER'S MAIDEN NAME LOUELLA VICE		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) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Eugene Calvert, No. 331X		ADDRESS No. 331X	
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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						INTERVAL BETWEEN ONSET AND DEATH 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage						
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from **9-18-1957** to **9-28-1957**, that I last saw the deceased alive on **9-28-1957**, and that death occurred at **4:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Edward L. Smith, M.D. (Degree or title)		23b. ADDRESS 107 9th St. Carrollton, Mo.		23c. DATE SIGNED 9-30-57	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10/2/57		24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem. Carrollton		24d. LOCATION (City, town, or county) (State) Mo	
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DATE REC'D BY LOCAL REG. 10-7-57		REGISTRAR'S SIGNATURE Thomas C. Dunder		25. FUNERAL DIRECTOR'S SIGNATURE STANLEY & GIBSON		ADDRESS CARROLLTON Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 *Ben W. Gibson*.....

Licensed Embalmer No. *296*.....

P. O. Address *Carrollton*.....

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.