

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015106  
STATE FILE NUMBER

FILED MAY 13 1958

Registration District No. 243 Primary Registration District No. 4364 Registrar's No. 621

S. 300  
v. 1-57  
930

1. PLACE OF DEATH a. COUNTY <b>Newton</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Newton</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Stella</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>0730</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cardwell Mem. Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>Stark, City R#</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Robert</b> Last <b>Crawford</b>			4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1958</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>Sept. 15 1881</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b>
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>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Clabourne Co. Tenn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Samuel Crawford</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Crawford</b>	
14. NAME OF HUSBAND OR WIFE <b>Belle Jones Crawford</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>500-09-4655</b>	
17. INFORMANT <b>Belle Crawford</b>		Address <b>Stark City, 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>Medullary paralysis</b> DUE TO (b) <b>Circulatory collapse</b> DUE TO (c) <b>Cardiac arrest</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic cardiovascular disease</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>Seconds</b>		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.)		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 <b>Stella, Missouri</b>		COUNTY STATE	
21. I attended the deceased from <b>MARCH 6, 1958</b> to <b>APRIL 13, 1958</b> and last saw <input checked="" type="checkbox"/> alive on <b>APRIL 13, 1958</b> Death occurred at <b>3:40 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>C. R. Holman D.O.</b>		(Degree or title) <b>D.O.</b>		22b. ADDRESS <b>Stella, Missouri</b>	
22c. DATE SIGNED <b>4-14-58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-15-58</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mound Chapel Cem.</b>		23d. LOCATION (City, town, or county) <b>Stark City, Mo. R#</b>		(State)	
24. FUNERAL DIRECTOR <b>W. Merristone Wheaton</b>		ADDRESS <b>Mo</b>		25. DATE RECD. BY LOCAL REG. <b>4-15-58</b>	
26. REGISTRAR'S SIGNATURE <b>Mildred Moberly</b>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

545

RECEIVED

District Health Officer No. Newton  
District File Number 558-102  
Date Filed MAY 6 1958

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 Wm Morris Ogden .....

Licensed Embalmer No. 7447 .....

P. O. Address Wheaton, Ill. .....

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.