

Health, Welfare, Public Service

1900  
1917

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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045070

STATE FILE NUMBER

DEC 22 1958 Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 79

1. PLACE OF DEATH a. COUNTY <b>Pemiscot</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pemiscot</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Caruthersville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Caruthersville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>911 E. 20th. St.</b>		Length of stay in lb <b>12 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>911 E. 20th. St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>Jones</b> Last <b>Green</b>			4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1885</b>	9. AGE (In years last birthday) <b>73</b>	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer- Day</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Coldwater, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Harrison Crawford</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Jean</b>		14. NAME OF HUSBAND OR WIFE <b>X</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>429 16 3689</b>		17. INFORMANT <b>Hillard Jones</b> Address <b>259 Grove St. Battle Creek, Mich.</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>Unknown- Natural- this person, an invalid, found dead at home. No fault play involved. No Medical attention.</b>					INTERVAL BETWEEN ONSET AND DEATH
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"/> <b>2-1</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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>about 3:30A</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>James A. Debus, Coroner 3</b>			22b. ADDRESS <b>Wardell, Mo.</b>		22c. DATE SIGNED <b>12-13-58</b>
22d. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22e. DATE <b>Dec. 16, 1958</b>	22f. NAME OF CEMETERY OR CREMATORY <b>Morgan Ridge Cemetery</b>		22g. LOCATION (City, town, or county) (State) <b>Caruthersville, Missouri</b>	
24. FUNERAL DIRECTOR <b>H.S. Smith Funeral Home-C'ville. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-15-1958</b>		26. REGISTRAR'S SIGNATURE <b>Fessie B. Weeks</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

DEC 17 1988

CAROTHERSVILLE, MO.

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 *W Denver Fike* .....

Licensed Embalmer No. *4404* .....

P. O. Address *Caruthersville, 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.