

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006736

STATE FILE NUMBER

FILED FEB 27 1959

Registration District No. 296

Primary Registration District No. 6018

Registrar's No. 4

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|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Ray | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ray | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fishing River Township | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Rayville, | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2 miles NE Elkhorn | | Length of stay in 1b 60 yrs. | d. STREET ADDRESS 2 miles NE Elkhorn R.F.D. #2 | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Hiram Middle Campbell Last Crowley | | | 4. DATE OF DEATH Month January Day 26 Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1875 | 9. AGE (In years last birthday) 83 | IF UNDER 1 YEAR Months 8 Days 6 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY General farming | 11. BIRTHPLACE (City and state or country) Rayville, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Thomas Crowley | | 13b. MOTHER'S MAIDEN NAME Mary Ann Wells | | 14. NAME OF HUSBAND OR WIFE Virilinda (Jones) Crowley | |
| 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. None | 17. INFORMANT Address Mrs. Virilinda Crowley, Rayville, Mo | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Chronic Cardio Renal Vascular Disease | | 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.) | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 1949 to 1/26/59 and last saw ^{xxx} him alive on 12/15/58 Death occurred at 11:00 A. M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Doctor E. Buchner MD | | | 22b. ADDRESS Jawson Mo. | | 22c. DATE SIGNED 2/2/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| Burial | Jan. 28, 1959 | Old New Garden | | Ray County Missouri | |
| 24. FUNERAL DIRECTOR Quest-Life Funeral Home Richmond, Missouri | | ADDRESS Richmond, Missouri | 25. DATE RECD. BY LOCAL REG. 2-10-59 | 26. REGISTRAR'S SIGNATURE Margaret DeKey | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

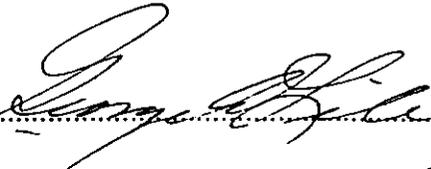
doctor, coroner, etc. must use only statement on reverse side. All diseases in Part I must be causally related.

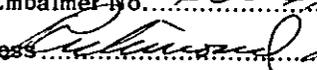
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STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 4065
P. O. Address 

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.