Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012839
STATE FILE NUMBER

FILED APR 17 1959 Registration District No. 109 Primary Registration District No. 4180 Registrar's No. 15

1. PLACE OF DEATH
a. COUNTY Dunklin
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Campbell — Inside Limits Yes [x] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Hwy 62 East — Length of stay in 1b: 50 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Dunklin
c. CITY OR TOWN 0350 Campbell — Inside Limits Yes [x] No [ ]
d. STREET ADDRESS (If outside, give location) Hwy 62 East — Reside on Farm Yes [ ] No [x]

3. NAME OF DECEASED (Type or print) First: MARY Middle: AUGUSTINE Last: CRAWFORD
4. DATE OF DEATH Month, Day, Year: March 31, 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [x] DIVORCED [ ]
8. DATE OF BIRTH: July 2, 1871
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months 8, Days 29 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Dunklin County, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME: William Alexander Davis
13b. MOTHER'S MAIDEN NAME: Dollie Eugenia Barnham
14. NAME OF HUSBAND OR WIFE: Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Elzie Crawford, Address: Campbell, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Complete Heart block — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardio-Vascular Disease — ? years.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4330
19. WAS AUTOPSY PERFORMED? YES [ ] NO [x]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 4/1/1950, to 3/30/59 and last saw her/him alive on 3/30/59
Death occurred at 7:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Wallace A Belsey MD
22b. ADDRESS: Campbell, Mo.
22c. DATE SIGNED: 4/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: April 3, 1959
23c. NAME OF CEMETERY OR CREMATORY: Tucker Cemetery
23d. LOCATION (City, town, or county) (State): Campbell, Missouri Rte. 2

24. FUNERAL DIRECTOR ADDRESS: Landess Funeral Home, Campbell, Mo.
25. DATE RECD. BY LOCAL REG.: 4-6-59
26. REGISTRAR'S SIGNATURE: Mrs Beulah Campbell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No.....

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.