

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024745**

FILED VS JUL 27 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 772

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in 1b <u>1 Day</u> c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <u>St Johns Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u> c. CITY OR TOWN <u>Buffalo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>East Star Rd.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>DEBRA</u> Middle <u>ANN</u> Last <u>CRAWFORD</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>19</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 19 1959</u>	<b>9. AGE</b> (Last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Day <u>1</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Buffalo mo</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>		
<b>13a. FATHER'S NAME</b> <u>Harvey Crawford</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Alpha June Reynolds</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u></u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	<b>17. INFORMANT</b> <u>Harvey Crawford</u> Address <u>Buffalo mo.</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hyaline Membrane Dis.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____							
<b>20d. INJURY PERFORMED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>7-18-59</u> to <u>7-19-59</u> and last saw <sup>her</sup> alive on <u>7-19-59</u> Death occurred at <u>11:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>Donald Overend M.D.</u> (Degree or title)			<b>22b. ADDRESS</b> <u>Springfield, Missouri</u>		<b>22c. DATE SIGNED</b> <u>7-22-59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>July 22 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Buffalo, mo.</u>				
<b>24. FUNERAL DIRECTOR</b> <u>L.B. Jones</u> ADDRESS <u>Buffalo, mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-23-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie E. Mellen</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

