

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

VS SEP 10 1959 333 3074 309B 154 59-031180  
 Registration District No. Primary Registration District No. Registrar's No. STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence/ before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		Length of stay in 1b	c. CITY OR TOWN <b>Sikeston</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>THEORIA</b> Middle <b>ZENORBIA</b> Last <b>CRAWFORD</b>	4. DATE OF DEATH Month <b>8</b> Day <b>29</b> Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-59</b>	9. AGE (last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>16</b>	IF UNDER 24 HR Hours <b>16</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <b>X X</b>	11. BIRTHPLACE (City and state or country) <b>Sikeston Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Walter Steward</b>	13b. MOTHER'S MAIDEN NAME <b>Lottie Crawford</b>	14. NAME OF HUSBAND OR WIFE <b>X</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>X</b>	16. SOCIAL SECURITY NO. <b>V X</b>	17. INFORMANT <b>Lottie Crawford, Sikeston</b> Address
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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>Brain Pneumonia Disinfectant &amp; dehydration</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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>Sikeston, Mo.</b>	COUNTY _____ STATE _____
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21. I attended the deceased from **8-29-59** to **8-29-59** and last saw her alive on **8-29-59**  
 Death occurred at **4:55 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Dr. James M. D.</b> (Degree or title)	22b. ADDRESS <b>Sikeston, Mo.</b>	22c. DATE SIGNED <b>8-30-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-30-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smith West End Cem West of Sikeston, Mo</b>	23d. LOCATION (City, town, or county) (State) <b>Mo</b>
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24. FUNERAL DIRECTOR <b>Fred J. Smith, Sikeston, Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-2-59</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**  
**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  
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. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.  
working under my personal supervision.

Student \_\_\_\_\_  
Student \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_

Signed Lud J. Smith  
Signed \_\_\_\_\_

Licensed Embalmer No. 4408  
Licensed Embalmer No. \_\_\_\_\_  
P. O. Address Sikeston  
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).  
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.  
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