

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000843

FILED VS JAN 26 1960 93

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 60-5 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo</u>		Length of stay in lb <u>17 Days</u>		c. CITY OR TOWN <u>Lockwood Mo Rt3</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6mi So</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Judson</u> Last <u>Crouch</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>15</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 3 1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Lawrence Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>usa</u>		
13a. FATHER'S NAME <u>Tillman Crouch</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Hunt</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Dump E Preston Lockwood Mo rt3</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years.</u>		
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			
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 _____ a.m. _____ p.m. Month, Day, Year _____									
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 <u>12-24-59</u> to <u>1-15-60</u> and last saw ^{her} <u>him</u> alive on <u>1-15-60</u> Death occurred at <u>4:20 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Emmeru. Taylor M.D.</u>				22b. ADDRESS <u>Lockwood, Mo</u>				22c. DATE SIGNED <u>1/18/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan 19 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Round Grove</u>		23d. LOCATION (City, town, or county) <u>Lawrence Co Mo.</u> (State)				
24. FUNERAL DIRECTOR ADDRESS <u>Allison Funeral Home Greenfield Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>1-21-1960</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 19 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Franklin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.