

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000866

FILED VS FEB 8 1960 098

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 31

STATE FILE NUMBER _____

1. PLACE OF DEATH a. COUNTY Daviess				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Daviess				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gallatin		Length of stay in lb 21 Yrs.		c. CITY OR TOWN Gallatin		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ---			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) ---		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEON Middle BAKER Last CRAWFORD				4. DATE OF DEATH Month January Day 25 Year 1960				
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 11-14-1887	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (City and state or country) Hurdland, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Milton Baker Crawford			13b. MOTHER'S MAIDEN NAME Eva Hall		14. NAME OF HUSBAND OR WIFE Jennie Crawford			
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. 490-10-3327		17. INFORMANT Address Gallatin, Mrs. Jennie L. Crawford, 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) Cerebral hemorrhage (second)							INTERVAL BETWEEN ONSET AND DEATH 2 days	
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) Cerebral hemorrhage (Aug 1959)					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 checked="" 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 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 Aug 1959 to Jan 25, 1960 and last saw her alive on Jan 25, 1960 . Death occurred at 12:10 P m on the date stated above and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Edward O. Nixon MD				22b. ADDRESS Gallatin Mo		22c. DATE SIGNED 2/1/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-27-1960	23c. NAME OF CEMETERY OR CREMATORY LaPlata Cemetery		23d. LOCATION (City, town, or county) LaPlata, Mo.			
24. FUNERAL DIRECTOR Hope Funeral Home, Gallatin, Mo.				25. DATE RECD. BY LOCAL REG. 4 Feb. 1960		26. REGISTRAR'S SIGNATURE Walter M. Engelhart		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 JUN 2 1960

STATEMENT BY LICENSED EMBALMER

FEB 1

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 L. O. Erickson

Licensed Embalmer No. 3302

P. O. Address Hallatin

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.