

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000917

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 4120 Registrar's No. _____

DED

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Campbell</u>		Length of stay in lb <u>38 yrs.</u>		c. CITY OR TOWN <u>Campbell</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>219 John Street</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>219 John Street</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>CRAWFORD</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>1960</u>				
5. SEX <u>Female</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>June 23, 1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Alabama</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>George Campbell</u>			13b. MOTHER'S MAIDEN NAME <u>Roxie Hopkins</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		
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 <u>Mrs. Bessie Cossairt, Campbell, Missouri</u> Address _____			
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>Acute Left Hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Arteriosclerotic C.V. Disease</u>						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 checked="" 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 <u>Campbell, Missouri</u>		STATE <u>Mo.</u>
21. I attended the deceased from <u>1/5/60</u> to <u>1/7/60</u> and last saw her ^{her} him alive on <u>1/7/60</u> . Death occurred at <u>1:45</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Wallace Belsey M.D.</u>				22b. ADDRESS <u>Campbell Mo.</u>		22c. DATE SIGNED <u>1/14/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 12, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tucker Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Campbell, Missouri Rte. 2</u>			
24. FUNERAL DIRECTOR <u>Landess Funeral Home, Campbell, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>1-15-1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Bessie Cossairt</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Christine M. Lande

Licensed Embalmer No. 4227
P. O. Address Campbell

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.