

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025548

STATE FILE NUMBER

FILED VS JUN 29 1960 956

Registration District No. 956 Primary Registration District No. 4521 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <b>Texas</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Houston</b>			Length of stay in 1b <b>4 das.</b>		c. CITY OR TOWN <b>Houston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR OUTPATIENT DEPARTMENT <b>Texas County Memorial Hospital</b>				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 <b>Jennie</b> Middle <b>Bell</b> Last <b>Richardson</b>				4. DATE OF DEATH Month <b>6</b> Day <b>16</b> Year <b>60</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/20/91</b>	9. AGE (last birthday) <b>69</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Raymondville, Mo.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>Joseph Crawford</b>			13b. MOTHER'S MAIDEN NAME <b>Harriett Rider</b>		14. NAME OF HUSBAND OR WIFE <b>Elmer</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Joe Richardson, Houston, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (b). <b>Diabetes Mellitus</b>						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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>6-14-60</b> to <b>6-16-60</b> and last saw her <b>her</b> on <b>6-16-60</b> Death occurred <b>8:15</b> <b>P</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Joe A. Wall MD</b>				22b. ADDRESS <b>Houston, Missouri</b>		22c. DATE SIGNED <b>6-18-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/19/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Allen Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Texas County, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Raymond E. Duff, Houston, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>6-27-60</b>		26. REGISTRAR'S SIGNATURE <b>Myrtie Craig</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

*Frank E. Moor*

Licensed Embalmer No. 4020

P. O. Address Houston

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.