

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 31 1960

=60-038152

STATE FILE NUMBER

Registration District No. 131 Primary Registration District No. 3023 Registrar's No. 270

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Clair Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Bates</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in 1b <u>1 wk.</u>		c. CITY OR TOWN <u>Urlich</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton Gen. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>Franklin</u> Last <u>Crabtree</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-1893</u>	9. AGE (last birthday) <u>67</u>	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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming Gen.</u>		11. BIRTHPLACE (City and state or country) <u>Bates Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Thomas Crabtree</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Neville Crabtree</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Neville Crabtree</u> Address <u>Urlich, Mo</u> <u>Rt 1</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>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
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			
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>1956</u> to <u>Oct 27, 1960</u> and last saw ^{her} _{him} alive on <u>Oct 27, 1960</u>				Death occurred at <u>11 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>Hugh B. Walker, MD</u>			22b. ADDRESS <u>Clinton, Mo</u>			22c. DATE SIGNED <u>Oct 29, 1960</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakhill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Butler, Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Culver-Underwood</u>		ADDRESS <u>Butler, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct, 29 - 1960</u>	26. REGISTRAR'S SIGNATURE <u>Nedra Bigem</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 7 AON

0961 8 AON

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert G. Steinduch

Licensed Embalmer No. 465

P. O. Address Burlington

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