

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-042731**

FILED VS NOV 29 1960

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 222

<b>1. PLACE OF DEATH</b> a. COUNTY <u>LIVINGSTON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Length of stay in 1b <u>1 week</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe City Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LIVINGSTON</u> c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.F.D. 1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William Daryl Crawford</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Nov 26 1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>CAU.</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Apr 20 1922</u>	<b>9. AGE</b> (last birthday) <u>68</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARMING</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Carroll County</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		
<b>13a. FATHER'S NAME</b> <u>Edward Crawford</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Jennie G. Mitchell</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Dorothy Beest Crawford</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>486-26-3689</u>		<b>17. INFORMANT</b> Address <u>Mr Dorothy Crawford, Chillicothe, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO (b) <u>uremia</u> <u>1 week</u> DUE TO (c) <u>Rupture of Kidney + Nephrectomy</u> <u>1 week</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>unknown</u>					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>Chillicothe Livingston Mo</u>			
<b>21. I attended the deceased from</b> <u>11-20-60</u> to <u>11-26-60</u> and last saw him alive on <u>11-26-60</u> Death occurred at <u>1:00 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>J.B. Wehber D.O.</u>			<b>22b. ADDRESS</b> <u>901 Jackson Chillicothe Mo</u>		<b>22c. DATE SIGNED</b> <u>11-26-60</u>		
<b>23a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>11-28-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Foels Branch</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Carroll, Mo.</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Dickerson Funeral Home, Boyard, Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>Nov. 26, 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Annalee Taylor</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 30 1960

DEC 14 1960

**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 Samuel M. Rice

Licensed Embalmer No. 508

P. O. Address Bogart

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