

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043131

ED VS NOV 20 1960

Registration District No. 291 Primary Registration District No. Registrar's No. 72

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY PUTNAM		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MO b. COUNTY PATNAN			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN LIVONIA		Length of stay in 1b 40 YRS		c. CITY OR TOWN LIVONIA	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) -	
3. NAME OF DECEASED (Type or print) GEORGE WILLIAM CRAWFORD		4. DATE OF DEATH NOV. 19 1960		5. SEX M	
6. COLOR OR RACE W		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-20-84	
9. AGE (last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		11. BIRTHPLACE (City and state or country) WARREN CO. IOWA	
13a. FATHER'S NAME JAMES CRAWFORD		13b. MOTHER'S MAIDEN NAME HANNA JANE FETTERS		14. NAME OF HUSBAND OR WIFE BERTHA 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. 11096		17. INFORMANT BERTHA CRAWFORD Address LIVONIA - 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) Degenerative myocarditis DUE TO (b) Cardiac Asthma DUE TO (c) _____ 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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 2-10-56 to 11-19-60 and last saw him alive on 11-18-60 Death occurred at 6:30 A on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) L.W. McDonald Do			22b. ADDRESS Unionville, Mo.		22c. DATE SIGNED 11-21-60
23b. DATE 11-21-60		23c. NAME OF CEMETERY OR CREMATORY St John		23d. LOCATION (City, town, or county) (State) LIVONIA MO	
24. FUNERAL DIRECTOR FD. HASTED		ADDRESS 509 UNIONVILLE		25. DATE RECD. BY LOCAL REG. 11-21-60	
				26. REGISTRAR'S SIGNATURE Marvell Durbin	

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Murl E. Nates

Licensed Embalmer No. 3309

P. O. Address Winnfield

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.