

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045690

FILED VS DEC 19 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1231

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>8 wks</u>		c. CITY OR TOWN <u>Seligman</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp.</u>			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 <u>HERBERT</u> Middle <u>MORRIS</u> Last <u>CREWS</u>				4. DATE OF DEATH Month <u>December</u> Day <u>10</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>8-2-1905</u>	9. AGE (last birthday) <u>55</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>mail carrier</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (City and state or country) <u>Crocker, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jonathan Crews</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara Kimmel</u>			14. NAME OF HUSBAND OR WIFE <u>Mabel Crews</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>491-44-0362</u>		17. INFORMANT Address <u>Mrs. Mabel Crews-Seligman, Missouri</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>Carcinoma stomach</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</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>1958</u> to <u>12-10-60</u> and last saw him alive on <u>12-10-60</u> Death occurred at <u>10</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (In care or title) <u>Elmer M Powell, MD</u>				22b. ADDRESS <u>609 Cherry St Springfield</u>		22c. DATE SIGNED <u>12-15-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-14-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crocker Cemetery</u>		23d. LOCATION (City, town, or county) <u>Crocker, Missouri</u>				
24. FUNERAL DIRECTOR <u>Culver's Cassville, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>12-16-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 28 1960

DEC 23 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 Margaret C. Herbes

Licensed Embalmer No. 4389

P. O. Address Cassville

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