

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-024295

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 171

AMENDED

FILED JUL 24 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |  |   |  |   |   |   |  |
|--|--|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Callaway</u>                      |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Fulton, Mo.</u>  |  |   | Length of stay in 1b<br><u>3 weeks</u>   |   | c. CITY OR TOWN<br><u>New Bloomfield, Mo.</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><u>Callaway Memorial Hosp.</u>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>           |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Eighty (Atie)</u> Middle <u>Bess</u> Last <u>Crisswell</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>20</u> Year <u>1961</u>  |   |   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>July 8 1880-81</u>                           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Callaway Co. USA</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>                           |  |
| 13a. FATHER'S NAME<br><u>Thomas Kemper</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Virginia Goff</u>                                    |   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Minor Crisswell</u>               |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |   | 16. SOCIAL SECURITY NO.<br><u>none</u>   |   | 17. INFORMANT<br><u>Russell Crisswell</u> Address <u>New Bloomfield</u>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute cerebral hemorrhage</u>   |  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 1/2</u>                                     |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>generalized arteriosclerosis.</u>  |  |   |  |   |   |   | <u>years</u>   |
| DUE TO (c)   |  |   |  |   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>acute cerebral lymphadenitis</u>   |  |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>7/6/61</u> to <u>7/20/61</u> and last saw her <sup>her</sup> <sub>deceased</sub> alive on <u>7/20/61</u><br>Death occurred at <u>2:50 P M</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |   |  |
| 22a. SIGNATURE <u>Henny Dusch M.D.</u> (Degree or title)   |  |   |  | 22b. ADDRESS <u>Fulton, Mo.</u>   |   | 22c. DATE SIGNED <u>7/21/61</u>                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>July 22, 61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Callaway Memorial Gardens</u>  |   | 23d. LOCATION (City, town, or county) (State)<br><u>Fulton, Mo.</u> |  |
| 24. FUNERAL DIRECTOR<br><u>LeRoy Claypool</u> ADDRESS <u>New Bloomfield, Mo.</u>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>July-21-1961</u>   |   | 26. REGISTRAR'S SIGNATURE<br><u>Maretha Lawrence</u>                |  |

SEP 19 1962

**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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomf

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.