

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029796

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 110

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 8 1962

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Webster</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		Length of stay in 1b <b>1Yr. 8mo.</b>	c. CITY OR TOWN <b>Rogersville</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #3</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.R.#3</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Omer Randal Crowe</b>			4. DATE OF DEATH Month Day Year <b>7 - 25 - 1962</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-1883</b>
9. AGE (last birthday) <b>79</b>		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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Indiana</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Alvin Crowe</b>	
13b. MOTHER'S MAIDEN NAME <b>Olive Wells</b>		14. NAME OF HUSBAND OR WIFE <b>Thelma Crowe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Hospital Record</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b>			<b>years.</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 Month, Day, Year a.m. p.m.			
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 <b>Nov. 15, 1960</b> to <b>July 25, 1962</b> and last saw him alive on <b>7-25-1962</b> Death occurred at <b>4:50 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Hilda Mungish M.P.</i>		22b. ADDRESS <b>State Hospital #3, Nevada, Mo.</b>	22c. DATE SIGNED <b>7-25-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-29-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Panther Valley Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Webster Co., Missouri</b>
24. FUNERAL DIRECTOR <b>Kelley-Ferrell</b>		ADDRESS <b>Rogersville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-4-1962</b>
		26. REGISTRAR'S SIGNATURE <i>Anna &amp; Jerry</i>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59

1 1085

2 1120

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9 4500

10

11

12 93-0

13 1-0

USE BLACK INK OR TYPEWRITER RIBBON

**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 Mr. P. T. Jewell

Licensed Embalmer No. 4910

P. O. Address Rogersville, Mo.

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.