

Dept: Health,  
Educ., & Welfare  
U. S. Public  
Health Service

FILED JAN 11 1963

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

=62-049424

STATE FILE NUMBER 132

Registration District No. 113 Primary Registration District No. 4185 Registrar's No.

V. S. 300  
Rev. 1-57

0362

1. PLACE OF DEATH a. COUNTY <b>Franklin</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Clair</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Clair</b> 0362		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>430 Jean St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>J.</b> Last <b>Crow</b>			4. DATE OF DEATH Month <b>12</b> Day <b>16</b> Year <b>62</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-1878</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Monroe County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>George W. Crow</b>		13b. MOTHER'S MAIDEN NAME <b>Maria Jane Mason</b>		14. NAME OF HUSBAND OR WIFE <b>Clarrissa</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>none</b>		17. INFORMANT <b>Carl Crow, St. Clair, Missouri</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>Chronic Bronchitis of Corium</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6. Mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>153.0</b>					
PART II/ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic obstructive pulmonary disease</b>					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>8-18-62</b> to _____ and last saw her/him alive on <b>12-16-62</b> . Death occurred at <b>St. Clair, Mo., 6:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>H. M. S. S. M. A. C.</b>			22b. ADDRESS <b>Union Mo</b>		22c. DATE SIGNED <b>12-18-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-19-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Clair Mo.</b>
24. FUNERAL DIRECTOR <b>Shirley E. Kitchell</b>		ADDRESS <b>St. Clair, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/19/62</b>	26. REGISTRAR'S SIGNATURE <b>Charley Smith</b>

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

3-0

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 *Shemond W. Kitchell*

Licensed Embalmer No. *3873*

P. O. Address *St. Clair, 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.