

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-01192  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 441

**FILED APR 1 1963**

VS 300  
Rev. 4/59

10397

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ:

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		c. CITY OR TOWN <u>SEYMOUR</u>	
Length of stay in 1b <u>4 WKS</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>BAPTIST HOSP'</u>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>FANNIE LOU MINNIE CRISWELL</u>			4. DATE OF DEATH Month Day Year <u>MARCH - 21 - 1963</u>
5. SEX <u>FEMALE</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>OCT. 6, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>67</u>
11. BIRTHPLACE (City and state or country) <u>GRAVELY, ARK.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>MARCUS O. RYAN'S</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA FINLEY</u>	14. NAME OF HUSBAND OR WIFE <u>BEN F. CRISWELL</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>NO</u> )		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>BEN F. CRISWELL</u>		Address <u>SEYMOUR, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a); stating the underlying cause last. DUE TO (b) <u>coronary atherosclerosis</u> DUE TO (c)			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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 checked="" 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>2-19-63</u> to <u>3-21-63</u> and last saw <sup>her</sup> alive on <u>3-21-63</u> Death occurred at <u>1:26 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robt. I. Stueffgen M.D.</u>		22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>3-26-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-25-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR MASONIC</u>	23d. LOCATION (City, town, or county) (State) <u>WEBSTER CO., MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Robert Berggren Seymour, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-27-63</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Matton</u>

USE BLACK INK OR TYPEWRITER RIBBON

APR 4 1963

**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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield 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.

Permit 3-21-63