

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0027296

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 5131 Registrar's No. 880

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 4 1966

VS 300  
 Rev. 4/59  
 1 5110  
 2 0830  
 3  
 4 0  
 5 1  
 6  
 7 0  
 8 2  
 9 X  
 10  
 11 511  
 12 91-0  
 13 1-0

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 ITEM NO.

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Platte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Tremont Twsp</b>		Length of stay in 1b <b>1day</b>	c. CITY OR TOWN <b>Weston</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>Perkins Creek, DD Hwy</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Raymond Crockett</b>			4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>April, 11, 1912</b>
9. AGE (last birthday) <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>DeKalb, Missouri</b>
13a. FATHER'S NAME <b>James Crockett</b>		13b. MOTHER'S MAIDEN NAME <b>Maggie Cline</b>	14. NAME OF HUSBAND OR WIFE <b>Catherine Crockett</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>91-10-9991</b>	17. INFORMANT Address <b>Catherine Crockett, Weston MO</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>Drowning</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Car overturn in creek</b>			<b>few min.</b>
DUE TO (c) <b>Car Accident</b>			
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 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 <b>8:30</b> a.m. Month, Day, Year <b>July 24, 1966</b>	<b>2 1/2 Miles SW of Gower Mo, 1 &amp; .8 miles W. of Clinton County Line, State road DD</b>		
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.) <b>County road</b>	20f. CITY, TOWN, OR LOCATION <b>St. Joseph, Buchanan, Missouri</b>	COUNTY STATE
21. I attended the deceased from <b>viewed</b> to <b>7/24/66</b> and last saw her/him alive on <b>viewed body</b> Death occurred at <b>8:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>McGinnis</i> (Degree or title)		22b. ADDRESS <b>St. Joseph, Mo</b>	22c. DATE SIGNED <b>7/25/66</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Turner Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Wallace Mo</b>
24. FUNERAL DIRECTOR <i>Paul Krupp</i> ADDRESS <b>St. Joseph Mo</b>		25. DATE RECD. BY LOCAL REG. <b>7-29-66</b>	26. REGISTRAR'S SIGNATURE <i>Mary Vollentine</i>

DOCUMENT

BY AFFIDAVIT OF M. E. Grimes M.D. MEDICAL CERTIFICATION

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

*John E. Rupp*

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.