

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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K35627

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36157  
Registrar's No. 1041-A

FILED DEC 13 1948  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREEN

(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Burge Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

In this community 2 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster

(c) City or town Niangua  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Clarabel Crawford

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas D. Crawford

6. (c) Age of husband or wife if alive 18 years  
(Day) (Year)

7. Birth date of deceased April  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>7</u>	<u>9</u>	hr. min.

9. Birthplace Unknown Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation MX Storekeeper

11. Industry or business Ladies Ready to wear

MOTHER FATHER

12. Name Ira Shuff

13. Birthplace Unknown Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Huffaker

15. Birthplace Unknown Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph V. Shuff

(b) Address 4509 Broadway, K.C., Mo

17. (a) Removal (b) Date thereof 11-28-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director W. J. Paine

(b) Address Marshallfield, Missouri

19. (a) 12-4-48 (b) W. E. Haulley, M.D.  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 27  
year 1948 hour 12: minute 45 P. M.

21. I hereby certify that I attended the deceased from Nov 25  
1948 to Nov 27 1948  
that I last saw him alive on Nov 27 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Alcohol

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Dyspepsia  
(Include pregnancy within 6 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 6

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature W. E. Haulley (M. D. or other)   
Address Springfield Mo Date signed Dec 4/48

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. 8312

P. O. Address. Marshfield, 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 this body is not embalmed, fact should be so stated above.**