

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

542

BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1116 Southwest Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1116 Southwest Blvd.			

3. NAME OF DECEASED (Type or Print)	a. (First) VINEY	b. (Middle) MAE	c. (Last) CROWE	4. DATE OF DEATH (Month) (Day) (Year) Feb. 10 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 11, 1877	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 1 Days 29	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Atlanta, Ga.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME W.M. Bramlett	13b. MOTHER'S MAIDEN NAME Elizabeth Hays	14. NAME OF HUSBAND OR WIFE John T. Crowe
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Clarence Rogers, Mayview, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus and DUE TO (c) Arterio-sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		260X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory; street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **10 Feb, 1950**, to **just called**, that I last saw the deceased alive on **10 Feb, 1950**, and that death occurred at **12:30 a.m.** the causes and on the date stated above.

23a. SIGNATURE John Wardlaw D (Degree or title)	23b. ADDRESS Lexington Mo.	23c. DATE SIGNED 2/10/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/12/50	24c. NAME OF CEMETERY OR CREMATORY Machpelah	24d. LOCATION (City, town, or county) (State) Lexington, Mo.
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DATE REC'D BY LOCAL REG. 17 Feb. 50	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR'S SIGNATURE 156 St. Louis St. Tempel Lee, Mo	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED FEB 21
District Health Officer No. 8,
District File Number _____
Date Filed 3-3-50

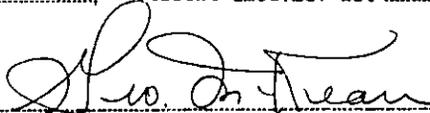
STATEMENT BY LICENSED EMBALMER

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.

Signed _____



Signed _____
Student Embalmer

Licensed Embalmer No. 2983

P. O. Address Lexington, 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.