

FILED JUL 10 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21747

State File No. \_\_\_\_\_ Registrar's No. 130

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: address before admission) a. STATE <i>Mo</i> b. COUNTY <i>Saline</i>	
b. CITY OR TOWN <i>Marshall</i>		c. CITY OR TOWN <i>Slater</i>	
c. LENGTH OF STAY (in this place) <i>30 hrs</i>		d. STREET ADDRESS (If rural, give location) <i>813 North Broadway</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Fitzgibbon-Hospital</i>			
3. NAME OF DECEASED a. (First) <i>Noah</i> b. (Middle) <i>Bryson</i> c. (Last) <i>Crawford</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>June 30 1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED-NEVER MARRIED, WIDOWED-DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb 27 1874</i>
9. AGE (If years, months, days) <i>74-3</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Retired Miller</i>	11. BIRTHPLACE (State or foreign country) <i>Sturgeon Mo</i>	12. CITIZENSHIP OF WHAT COUNTRY <i>USA</i>
10a. USUAL OCCUPATION	10b. KIND OF BUSINESS OR INDUSTRY <i>Flour mill</i>	11. BIRTHPLACE	12. CITIZENSHIP OF WHAT COUNTRY
13a. FATHER'S NAME <i>Wm Crawford</i>		13b. MOTHER'S MAIDEN NAME <i>Lucretia Glass</i>	
14. NAME OF HUSBAND OR WIFE <i>Bertie Jane Crawford</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>487-01-5711</i>	
17. INFORMANT'S SIGNATURE OR NAME <i>Mrs Bertie Jane Crawford</i>		ADDRESS <i>Slater Mo</i>	
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, asthma, etc. It means the disease, injury, or complication which caused death.			19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <i>Pneumonia 234 Curved</i> II. OTHER SIGNIFICANT CONDITIONS <i>Respiratory pneumonia</i> Conditions contributing to the death but not related to the disease or condition causing death. <i>69020 21</i>
18. CAUSE OF DEATH			19. MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <i>Pneumonia 234 Curved</i>			INTERVAL BETWEEN ONSET AND DEATH <i>30 hr</i>
II. OTHER SIGNIFICANT CONDITIONS <i>Respiratory pneumonia</i>			<i>60 hr</i>
			<i>1</i>
19a. DATE OF OPERATION <i>None</i>			19b. MAJOR FINDINGS OF OPERATION <i>None</i>
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE? <i>Falling</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.) <i>Next door to his home</i>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Slater Mo Saline</i>			
21d. TIME OF INJURY (Month) (Day) (Year) <i>6 27 1951</i>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Falling into drain ways</i>		7 ft deep	
22. I hereby certify that I attended the deceased from <i>6-29</i> 19 <i>51</i> to <i>Jan 30</i> 19 <i>51</i> ; that I last saw the deceased alive on <i>6-30</i> 19 <i>51</i> , and that death occurred at <i>3:30</i> m., from the causes and on the date stated above.			
23a. SIGNATURE <i>D. E. Coates</i>		23b. ADDRESS <i>Slater Mo</i>	
23c. DATE SIGNED <i>6 30 51</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>July 2 1951</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Centralia Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Centralia Mo</i>	
DATE REC'D BY LOCAL REG. <i>July 1 1951</i>		REGISTRAR'S SIGNATURE <i>Chidney F Gray</i>	
385		FUNERAL DIRECTOR'S SIGNATURE <i>Jones &amp; Salge</i>	
		ADDRESS <i>Slater Mo</i>	

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

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**RECEIVED** 7-9-57  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed 7-9-57

JUN 28 1957

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Signed

Licensed Embalmer No. 2143

P. O. Address State No

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.