

FILED JUL 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21964

State File No.

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 5003 Registrar's No. 210

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Morrow Twp		c. LENGTH OF STAY (In this place) 2 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 1, Green Castle		d. STREET ADDRESS (If rural, give location) Route 1, Green Castle	
3. NAME OF DECEASED (Type or Print) a. (First) Nancy b. (Middle) Elizabeth c. (Last) Crawford		4. DATE OF DEATH (Month) (Day) (Year) July 21, 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 3, 1867
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Charles Powell		13b. MOTHER'S MAIDEN NAME Sarah Beets	14. NAME OF HUSBAND OR WIFE Howard Crawford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Bland Kimberly, Green Castle,
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF CAECUM AND ILEO-CAECAL VALVE ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	
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?	
22. I hereby certify that I attended the deceased from Sept 12, 1947 to July 21, 1954 , that I last saw the deceased alive on July 21, 1954 , and that death occurred at 6 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE R. B. Smith, D.O. (Degree or title)		23b. ADDRESS Green City, Mo.	23c. DATE SIGNED July 23, 1954
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 24, 1954	24c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery	24d. LOCATION (City, town, or county) (State) Green Castle, Mo.
DATE REC'D BY LOCAL REG. 7-24-54	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Glenn E. Funt & Son, Green City, Mo.	

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
Student Embalmer

Signed Karl P. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, 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.