

FILED AUG 6 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24418**
Registrar's No. **7108**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS 2220 1/2 Cole	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or Print) Bill		a. (First) Bill b. (Middle) c. (Last) Crow	4. DATE OF DEATH (Month) (Day) (Year) July 30, 1954
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 1867
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Carroll County, Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Jim Crow	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Betty Crow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Lovie Johnson ADDRESS 2220 1/2 Cole St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH Undt	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		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? 331X	
22. I hereby certify that I attended the deceased from July 23, 1954 , to July 30, 1954 , that I last saw the deceased alive on July 30, 1954 , and that death occurred at 9:05 a. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) C. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 7/30/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 31, 1954	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Poplar Bluff, Missouri, Mo.
DATE REC'D BY LOCAL REG. JUL 31 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Wm Smith's Funeral Home ADDRESS 4019 Wash-	

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.....


Licensed Embalmer No. 43.....

P. O. Address St. Rose.....

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.

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