

FILED DEC 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37030

State File No.

BIRTH NO. 51928-54 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1070-B

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Christian	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 45 Mins.	c. CITY OR TOWN "Rural" Porter
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		e. STREET ADDRESS (If rural, give location) Route #1, Nixa	

3. NAME OF DECEASED (Type or Print)	a. (First) MARSHA	b. (Middle) KAY	c. (Last) CRAIN	4. DATE OF DEATH (Month) (Day) (Year) Nov. 23, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Aug. 21, 1954	9. AGE (In years last birthday) IF UNDER 1 YEAR 0 Months 3 Days	IF UNDER 24 HRS. Hours 2 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY - - - -	11. BIRTHPLACE (City, town, or village, State or Foreign Country) Springfield, Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Paul Franklin Crain	13b. MOTHER'S MAIDEN NAME Berna Deane Perkins	14. NAME OF HUSBAND OR WIFE None
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Paul F. Crain, Rt. #1, Nixa, 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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ac. Toxic Myocarditis		
	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 7544	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Minute)	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 11/22, 1954, to 11/23, 1954, that I last saw the deceased alive on 11/22, 1954, and that death occurred at 12-45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>[Signature]</i>	23b. ADDRESS 609 Cherry St Springfield Mo	23c. DATE SIGNED 11/26/54
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24a. BURIAL CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 26, 54	24c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
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DATE REC'D BY LOCAL REG. 11-29-54	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS Clever, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *John Alean Harris*

Licensed Embalmer No..... *4390*

P. O. Address..... *Claver, Va.*

**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.**