

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18264

State File No.

FILED JUN 20 1955

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 510

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>30 days</u>	c. CITY OR TOWN <u>Springfield</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St John's Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>323 South Weller</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ALSEY</u>	b. (Middle) <u>B.</u>	c. (Last) <u>CRAWFORD</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 12 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 21, 1890</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____	IF UNDER 6 WKS. Hours _____	Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner Manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Addino Machine Co</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Little Rock, Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Albert Crawford</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Tully</u>	14. NAME OF HUSBAND OR WIFE <u>Oma Crawford</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Oma Crawford, Springfield, Mo.</u>	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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Larynx with metastases</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid 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 <u>12-18-53</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Larynx</u>	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) _____	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 8-17, 1953, to 12 June, 1955, that I last saw the deceased alive on 12 June, 1955, and that death occurred at 1:40 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Alon J. Gose M.D.</u>	(Degree or title) _____	23b. ADDRESS <u>Professional Bldg, Springfield, Mo 6-14-55</u>	23c. DATE SIGNED _____
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 14, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>6-15-55</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Lohmeyer, Springfield, Mo.</u>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

JUN 23 1958

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..... *Bernard F. Wray*

Licensed Embalmer No. *42*

P. O. Address *Spring*

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.