

FILED APR 11 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9614**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **5635** Registrar's No. **54**

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Laclede</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Phillipsburg</b> c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>Phillipsburg</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Rural Route # 1</b>		e. STREET ADDRESS (If rural, give location) <b>Rural Route # 1.</b>	
3. NAME OF DECEASED (First) <b>Sarah Jane</b> (Middle) <b>Crabaugh</b> (Last) _____		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>26</b> (Year) <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 11, 1866</b>
9. AGE (In years last birthday) <b>89</b> IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b> IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Dallas Co. Mo.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>E.W. Richardson</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah Ellen Pulse</b>		14. NAME OF HUSBAND OR WIFE <b>John H. Crabaugh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Bessie Marshall</b>		ADDRESS <b>Phillipsburg, Mo.</b>	
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, arterio, etc. It means the disease, injury, or complication which caused death.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronaria Pictoria</b>		INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Myocarditis</b>		<b>-</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"/>		<b>4202</b>	
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 <b>2-20, 1956</b> to <b>3-26, 1956</b> , that I last saw the deceased alive on <b>2-20, 1956</b> , and that death occurred at <b>11 P. M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Dr. Hindley M.D.</b> (Degree or title) _____		23b. ADDRESS <b>Canaway Mo.</b>	
23c. DATE SIGNED <b>3-29-56</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>3/29/56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Hope Cemetery near Long Lane Mo.</b>	
24d. LOCATION (City, town, or county) _____ (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albella L. Hays</b> ADDRESS <b>Holman Funeral Home Lebanon, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>3-29-1956</b>		REGISTRAR'S SIGNATURE _____	

(Licensed Embalmer's Statement on Reverse Side)

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

+240

Received 4-9-56  
Laclede County Health Unit  
File No. 54  
Date Filed 4-9-56

---

---

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 Harvey M. Howe

Licensed Embalmer No. 422

P. O. Address Lebanon

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.