

Health,
& Welfare
S. Public
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v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 38 Primary Registration District No. 5120 Registrar's No. 443

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Centralia</u> <u>Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Rest Home</u>		Length of stay in 1b <u>5 Mo.</u>	d. STREET ADDRESS (If outside, give location) <u>5. Heckman ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>J.</u> Last <u>Crawford</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 - 1874</u>		9. AGE (In years last birthday) <u>83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTH PLACE (City and state or country) <u>Andrew Co. Missouri</u>	
13. FATHER'S NAME <u>Andrew Powell</u>			14. MOTHER'S MAIDEN NAME <u>Ann Turner</u>		
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>487-01-5711</u>		17. INFORMANT <u>Mrs. Nettie F. Crump, Centralia, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>331X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>20 yrs.</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. CITY, TOWN, OR LOCATION <u>-</u>	
21. I attended the deceased from <u>July 1 - 87</u> , to <u>Dec. 2 5:00 A</u> and last saw her/him alive on <u>Nov. 29 - 57</u> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>F. C. Quiggert M.D.</u> (Degree or title)		22b. ADDRESS <u>Columbia Mo</u>		22c. DATE SIGNED <u>12/3/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 4 - 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centralia Cemetery</u>	
		23d. LOCATION (City, town, or county) <u>Centralia, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Loe O. Ballou, Centralia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 3 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmate</u>	

(Licensed Embalmer's Statement on Reverse Side)

AUG 27 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 *Paul J. Baller*

Licensed Embalmer No. *420*

P. O. Address *Centralia,*

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.