

1. Health, & Welfare
 5. Public Health Service

S. 300
 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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

STANDARD CERTIFICATE OF DEATH

40141

STATE FILE NUMBER

FILED NOV 27 1957

Registration District No. 143 Primary Registration District No. 5559 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY Howell				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN Hutton Valley			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Hutton Valley		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CORDELIA DICA CROUCH				First	Middle	Last	4. DATE OF DEATH Nov. 17, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1887		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 11 Days 10	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and state or country) Shannon County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E				14. MOTHER'S MAIDEN NAME Sarah Murry				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no none		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Loutishe Griffin RR2 Willow Springs				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocarditis							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Bronchitis & asthma						
		DUE TO (c) Chronic myocarditis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholecystitis.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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.)					
20c. TIME OF INJURY Hour 3:15 PM Month, Day, Year								
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from 7/1-57 to 11-12-57 and last saw her alive on 11/12/57 Death occurred at 3:15 PM m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Harold W. Miller M.D.				22b. ADDRESS Willow Springs Mo.			22c. DATE SIGNED 11-21-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)		(State)
Burial		11/19/57	Lost Camp			Howell County, Mo.		
24. FUNERAL DIRECTOR Burns Willow Springs, Mo.				25. DATE RECD. BY LOCAL REG. 11/23/57		26. REGISTRAR'S SIGNATURE Marshall Ballard		

(Licensed Embelmer's Statement on Reverse Side)

NOV 27 1957

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

Fred W. Barnes
Signed Fred W. Barnes

Licensed Embalmer No 4614

P. O. Address Willow 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.