

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 20 1959

59-331179 STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 142

DEED

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Scott</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Sikeston</b>		Length of stay in 1b <b>10yr.</b>		c. CITY OR TOWN <b>Sikeston, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>				d. STREET ADDRESS <b>Sikeston, Mo.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MALISSA CRAWFORD</b>			4. DATE OF DEATH Month Day Year <b>8 5 1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Celera</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12, 6, 1908</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>7 28</b>		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House wife</b>		11. BIRTHPLACE (City and state or country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>Albert Meeks</b>			13b. MOTHER'S MAIDEN NAME <b>Hattie Nelson</b>		14. NAME OF HUSBAND OR WIFE <b>Widowed</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Reg. Meeks Sikeston, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 a.m. p.m. 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 <b>Aug 5, 1959</b> to <b>Aug 5, 1959</b> and last saw <sup>her</sup> him alive on <b>Aug 5, 1959</b> Death occurred at <b>2:25 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Wm. C. Critchlow M.D.</b>				22b. ADDRESS <b>Sikeston, Mo.</b>		22c. DATE SIGNED <b>Aug 6-1959</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8-9-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smith West End Court</b>		23d. LOCATION (City, town, or county) (State) <b>West 7 Sikeston, Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Fred J. Smith Sikeston, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>8-11-59</b>		26. REGISTRAR'S SIGNATURE <b>Martha Hunter</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 8 8 9071

STATEMENT BY LICENSED EMBALMER  
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.  
working under my personal supervision.

Student \_\_\_\_\_  
Student \_\_\_\_\_  
Signature of Student Embalmer  
Signature of Student Embalmer

Signed Fred J. Smith  
Signed \_\_\_\_\_

Licensed Embalmer No. 4408  
Licensed Embalmer No. \_\_\_\_\_  
P. O. Address Wickertown  
P. O. Address \_\_\_\_\_

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.)  
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, the association signature must be in the STUDENT's OWN handwriting.  
If this body is not embalmed, fact should be so stated above.  
If this body is not embalmed, fact should be so stated above.