

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005185

FILED VS. FEB. 23 1960 042

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207

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Buchanan</b>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in lb <b>life</b>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>906 Robidoux St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>1402 N. 10th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>LODA</b> Middle <b>BELLE</b> Last <b>CRAWFORD</b>				4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1960</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</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>6/30/1898</b>		9. AGE (last birthday) <b>61</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>attendant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>State Hospital</b>		11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Charles Scott</b>			13b. MOTHER'S MAIDEN NAME <b>Edna Saunder</b>			14. NAME OF HUSBAND OR WIFE <b>John Crawford</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>494-34-0929</b>		17. INFORMANT <b>Mrs. Edwin Wallace, 1402 N. 10th, St. Joseph,</b> Address				
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>Cancer of Breast</b>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							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 checked="" 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>1958</b> to <b>death</b> and last saw her alive on <b>2-11-60</b> Death occurred at <b>6:00 p.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Joseph L. Fisher M.D.</b> (Degree or title)				22b. ADDRESS <b>702 Julie St.</b>		22c. DATE SIGNED <b>2-17-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>2/16/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Joseph Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Heaton - Bowman, St. Joseph, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Feb. 18, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>			

DOCUMENT

J. L. Fisher, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr. Fred*

**STATEMENT BY LICENSED EMBALMER**

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. \_\_\_\_\_  
working under my personal supervision.

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

Signed *William J. Spalding*

Licensed Embalmer No. 4535

P. O. Address *St. Joseph 4th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.