

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

=60-022034

FILED VS MAY 25 1960

STATE FILE NUMBER

UNRECORDED

Registration District No. 391 Primary Registration District No. 4505 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Capegirardell</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bell City.</u>		Length of stay in 1b <u>2 years</u>	c. CITY OR TOWN <u>Delta.</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>Bell City, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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) First <u>Perry</u> Middle <u>Alexander</u> Last <u>Crawford</u>			4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1864</u>	9. AGE (last birthday) <u>96</u>	IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>John City, Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Martha Snider.</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>None</u>		17. INFORMANT <u>Hugh Crawford, Delta, 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>Medullary failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u> </u> DUE TO (b) <u>Circulatory failure</u> DUE TO (c) <u>Coronary thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u> <u>2 DAYS</u> <u>12 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Septicemia due to kidneys</u>				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.) <u> </u>		
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>11-1-60</u> to <u>3-31-60</u> and last saw him alive on <u>3-30-60</u> Death occurred at <u>11:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deputy or title) <u>S. A. Masters</u>		22b. ADDRESS <u>Advance No 41960</u>		22c. DATE SIGNED <u>4-2-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-2-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kenyon Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Delta, Mo</u>
24. FUNERAL DIRECTOR <u>Shelley Funeral Home Bell City Mo.</u>		ADDRESS <u> </u>		25. DATE RECD. BY LOCAL REG. <u>4/19/60</u>	26. REGISTRAR'S SIGNATURE <u>Service Moore</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Raymond L. Ruffin

Licensed Embalmer No. 4798

P. O. Address Berme

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.