

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027901

STATE FILE NUMBER

Registration District No. 224 Primary Registration District No. 2046 Registrar's No. 48

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

6681
20680

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4 0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p style="font-size: 18pt; font-weight: bold;">FILED JUL 23 1962</p> <p>1. PLACE OF DEATH a. COUNTY <u>Moniteau</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Eadsburg</u> Length of stay in 1b <u>3 weeks</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Latham Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Moniteau</u></p> <p>c. CITY OR TOWN <u>Enon</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Chester Crawford</u></p>			<p>4. DATE OF DEATH Month Day Year <u>July 14 1962</u></p>		
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>Caucasian</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>7/30/98</u></p>	<p>9. AGE (last birthday) <u>73</u></p>	<p>IF UNDER 1 YEAR Months Days Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switchman</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. R.R.</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Bloomfield, Mo.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>		<p>13a. FATHER'S NAME <u>William Crawford</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Martha Ella Glenn</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>Fay Willis Crawford</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W.W.I</u></p>			
<p>16. SOCIAL SECURITY NO. <u>Unknown</u></p>		<p>17. INFORMANT Address <u>Mrs. Fay Crawford, Enon, Mo.</u></p>			
<p>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>Carcinoma of lung (left)</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p>					<p>INTERVAL BETWEEN ONSET AND DEATH <u>2 years.</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>					<p>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</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>		
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>				
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>			
<p>21. I attended the deceased from <u>6-5-60</u> to <u>7-14-62</u> and last saw ^{her}him alive on <u>7-14-62</u> Death occurred at <u>10 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>					
<p>22a. SIGNATURE (Degree or title) <u>Kennon Latham M.D.</u></p>			<p>22b. ADDRESS <u>California, Mo</u></p>		<p>22c. DATE SIGNED <u>7-14-62</u></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>7/17/62</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Antioch</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>Bloomfield Mo.</u></p>	
<p>24. FUNERAL DIRECTOR ADDRESS <u>Phillips Funeral Home Eldon, Mo.</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>7/16/1962</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Helen A. Pappay</u></p>		

USE BLACK INK OR TYPEWRITER RIBBON

JUL 24 1962

MS JUL 24 1962

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 Don E. Phellegis

Licensed Embalmer No. 5108

P. O. Address Elkhart

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.