

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043702

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 174

FILED DEC 2 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> COUNTY <u>Orange</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains,</u>		Length of stay in 1b <u>7 months</u>	c. CITY OR TOWN <u>Buena Park</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>W. P. Memorial Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8857 San Antonio Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lola May Crawford</u>			4. DATE OF DEATH Month Day Year <u>11-25-1963</u>
5. SEX <u>Female</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>12-17-1893</u>
9. AGE (last birthday) <u>69 years</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state of country) <u>State Of Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Sportsman</u>	
13b. MOTHER'S MAIDEN NAME <u>Docie ?</u>		14. NAME OF HUSBAND OR WIFE <u>James Wesley S. Crawford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)		16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT Address <u>Marion Crawford Rtn 2 West Plains 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>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>DOE TO (b) Osteoarthritis</u> <u>DOE TO (c) Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
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 <u>9-9-63</u> to <u>25-11-63</u> and last saw her alive on <u>24-11-63</u> Death occurred at <u>0530 hrs</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>27/11/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-26-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>[redacted]</u>	23d. LOCATION (City, town, or county) (State) <u>Greenville, Texas</u>
24. FUNERAL DIRECTOR ADDRESS <u>Robertson Funeral Home W. P. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-30-63</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

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 *D. D. Roberts*

Licensed Embalmer No. 3442

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).
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.