

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043703

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 164
FILED NOV 18 1963

| | |
|--|--------------|
| VS 300 Rev. 4/59 | DATE AMENDED |
| 1 <u>0465</u> | |
| 2 <u>0415</u> | |
| 3 | |
| 4 <u>0</u> | |
| 5 <u>1</u> | |
| 6 | |
| 7 <u>1</u> | |
| 8 <u>2</u> | |
| <u>932X</u> | |
| 10 | |
| 11 | |
| 12 <u>90-0</u> | |
| 13 <u>1-0</u> | |
| AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF |
| ITEM NO. | SHOULD READ |
| BY AFFIDAVIT OF | DOCUMENT |

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Howell</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Howell</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> | | Length of stay in 1b | c. CITY OR TOWN <u>West Plains</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Plains, Missouri</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>West Plains, Missouri</u> |
| 3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle Last <u>Crow</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1963</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-10-1878</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) <u>84 Yrs.</u> |
| 11. BIRTHPLACE (City and state or country) <u>Lucas, Ia.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Crow</u> | | 13b. MOTHER'S MAIDEN NAME <u>Maggie Langston</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Mary A. Green Crow</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) | |
| 16. INFORMANT NO. <u>32</u> | | Address <u>Mrs. Tom Crow 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>Cerebral Thrombosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> | | | <u>10 yrs</u> |
| DUE TO (c) | | | |
| 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 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 _____ s.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>12/19/1949</u> to <u>11/6/1963</u> and last saw him ^{XX} alive on <u>11/5/1963</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>J. Callihan M.D.</u> (Degree or title) | | 22b. ADDRESS <u>West Plains, Mo</u> | 22c. DATE SIGNED <u>11-13-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-10-1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u> | 23d. LOCATION (City, town, or county) <u>West Plains, Missouri</u> (State) |
| 24. FUNERAL DIRECTOR <u>Robertson Funeral Home West Plains, Mo</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>11-16-63</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. A. Robertson

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.