

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0034921

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1418

FILED SEP 25 1967

1. PLACE OF DEATH

a. COUNTY

Greene

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

Springfield

Length of stay in 1b

25 days

c. FULL NAME OF
HOSPITAL OR
INSTITUTION

Burge Protestant

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

Wright

c. CITY
OR TOWN

MANSfield

Inside Limits

Yes ☒ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

MARY

MAUDE CRAWFORD

4. DATE
OF DEATH

Month

Day

Year

Sept. 13 1967

5. SEX

F

6. COLOR OR RACE

W

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

5-6-1914

9. AGE (last birthday)

53

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (City and state or country)

California Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Luther Bybee

13b. MOTHER'S MAIDEN NAME

Annie Reed

14. NAME OF HUSBAND OR WIFE

D.N.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Not Available

17. INFORMANT

D.N. Crawford

Address

MANSfield Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of Ovary

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

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 ☐ NOT WHILE AT WORK ☐

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 _____, to _____ and last saw her him alive on 9-13-67
Death occurred at 8:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

F. J. Ellis MD

22b. ADDRESS

Springfield Mo

22c. DATE SIGNED

9-18-67

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

Sept. 13, 1967

23c. NAME OF CEMETERY OR CREMATORY

City

23d. LOCATION (City, town, or county)

California

(State)

Mo.

24. FUNERAL DIRECTOR

ADDRESS

MAX L Miller

MANSfield Mo.

25. DATE RECD. BY LOCAL REG.

9-20-67

26. REGISTRAR'S SIGNATURE

Bernice Midway

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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

Max E. Miller

Licensed Embalmer No.

4720

P. O. Address

Mansfield Mo.

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.