PERMANENT RECORD

d EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important.

N. B

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Dent

Township: _____ or Village: _____ or City: Salem Mo. (NO. _____ St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 266 File No. 25861

Primary Registration District No. 4164 Registered No. 35

FULL NAME Silvester Hage Crigler

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Mar 19 (Month) (Day), 1841 (Year)

AGE: 71 yrs. 5 mos. 7 ds. (If LESS than 1 day, ____ hrs. or ____ min.?)

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 0 - 0

BIRTHPLACE (City or town, State or foreign country): Ralls Co Mo.

PARENTS

NAME OF FATHER: Silas Crigler

BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky

MAIDEN NAME OF MOTHER: Katherine Zimmerman

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): John C. Zweig.

(ADDRESS): Salem Mo.

Filed Aug 27 1912 J. C. Welch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug 26 (Month) (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec, 1912, to Aug 26, 1912, that I last saw him alive on Aug 26, 1912, and that death occurred, on the date stated above, at 2:10 P.m.

The CAUSE OF DEATH* was as follows:

Cystitis and Nephritis

(Duration) 2 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. T. McMurtry M. D.

Aug 27, 1912 (Address) Salem Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State 71 yrs. 5 mos. 7 ds.

Where was disease contracted if not at place of death? At place of death

Former or usual residence: Ralls Co Mo

PLACE OF BURIAL OR REMOVAL: Cedar Grove

DATE OF BURIAL: Aug 27 1912

UNDERTAKER: J. C. Zweig.

ADDRESS: Salem Mo.

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____ _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, _____ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS