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.

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

PLACE OF DEATH

County Adair

Township or Village or City Kirksville (NO. 310 E McP St.; Ward)

Registration District No. 4 File No. 11499

Primary Registration District No. 3001 Registered No. 183

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

FULL NAME Henery Martin Criam

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Sept 2nd (Month) (Day), 1864 (Year)

AGE 49 yrs. 7 mos. 15 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farming

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

PARENTS
NAME OF FATHER James H Criam
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentuckey
MAIDEN NAME OF MOTHER Sarah Bunk
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana 8

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Crim

(ADDRESS) 310 E McPherson St

Filed 4 17 1914 A W Parish REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2

DATE OF DEATH April 17 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from April 16, 1914, to April 17, 1914, that I last saw him alive on April 16, 1914, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Mitral insuficiency 131 92A

120

(Duration) 6 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis.

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) E. A. Grim M. D.

Apr 17 1914 (Address) Kirksville 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 ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Edina Mo

DATE OF BURIAL 4 18 1914

UNDERTAKER H. C. Wilson

ADDRESS Kirksville

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) ....., 1..... (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

..... (Month) ..... (Day), 191..... (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