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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

PLACE OF DEATH

County: Andrain

Township or Village or City: Laddonia Mo

Registration District No. 24 — Primary Registration District No. 4018 — File No. 54 — Registered No.

(NO. ____ St. ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William C. Crail (Crail)

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	W.	Sing

DATE OF BIRTH: Dont Know (Month) 1 (Day) (Year)

AGE: Dont Know yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Dont Know
(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) T M Monroe

(ADDRESS) Laddonia Mo

Filed Jan. 4 1917. T M Monroe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. (Month) 4 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from December 10, 1916, to Jan. 3, 1917, that I last saw him alive on Jan. 3, 1917, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs
2314
28
(Duration) yrs. mos. ds.

Contributory (SECONDARY) Dont Know
(Duration) yrs. mos. ds.

(Signed) T M Monroe M. D.
Jan 6 1917 (Address) Laddonia 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: Laddonia Mo — DATE OF BURIAL: Jan 4 1917

UNDERTAKER: H. G. Georgen — ADDRESS: Laddonia Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough;*

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEA

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.;.....Ward)

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1.....
(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 DEA

DATE OF DEATH

.....
(Month)

I HEREBY CERTIFY, that I atte

....., 191...., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths f (1) Means of Injury; and (2) whether Accidental, Suicidal,

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTIT RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL | D

UNDERTAKER | A