Dr. Brainard

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Monroe

Township Wood Lawn — Registration District No. 587 — File No. 14025

or

Village — Primary Registration District No. 1585 — Registered No. 7

or

City (NO. St.; Ward)

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

2 FULL NAME Jerry Hall. Crawford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Dec 20, 1839 (Month) (Day) (Year)

7 AGE: 78 yrs. 3 mos. 15 ds. — If LESS than 1 day, ...hrs. or ....min.?

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

9 BIRTHPLACE (City or town, State or foreign country): N. York

PARENTS

10 NAME OF FATHER: Hyrum Crawford

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): N. York

12 MAIDEN NAME OF MOTHER: Lucy Turner

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): N. York.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hattie M. Walker

(Address) Madison R.F.D.

15

Filed Ap 6, 1918 Ferd. Weddi

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 5, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mch 1, 1918, to Apr 5, 1918, that I last saw him alive on Apr 5, 1918, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

93C

(Duration) 4 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary): Dropsy

(Duration) ....yrs. ....mos. 20 ds.

(Signed) L. Brainard M. D.

Apr 6, 1918 (Address) Dunearn Bridge Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Alexander Cemetery — DATE OF BURIAL: 4-6, 1918

[illegible]RTAKER: E. Hopper — ADDRESS: Clarence

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

If death occurr hospital or inst give its NAME of street and nu

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE
.....yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...

Re

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
....., 191
(Month) (Day)

17 I HEREBY CERTIFY, that I attended decease
....., 191....., to ....., 19
that I last saw h.....alive on ....., 19
and that death occurred, on the date stated above, at .....
The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos.

(Signed) .....

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

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or Recent Residents)

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
..... 1

20 UNDERTAKER | ADDRESS