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

33428

1 PLACE OF DEATH

County Jasper

Township or Village Webb City or City Jasper Co Tuberculosis Hospital (No. St. Ward)

Registration District No. 417 File No.

Primary Registration District No. 3021 Registered No. 202

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

2 FULL NAME Leonidas S. Crockett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

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

6 DATE OF BIRTH: Oct (Month) 2 (Day), 1881 (Year)

7 AGE: 38 yrs. 1 mos. 27 ds. If LESS than 1 day, ... hrs. or ... min.?

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

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

PARENTS

10 NAME OF FATHER: Samuel Crockett

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

12 MAIDEN NAME OF MOTHER: Emma E Thornton

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ross Burns
(Address) Joplin Mo

15 Filed Dec 1, 1919, C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 11 (Month) 29 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 6-13, 1919, to 11-29, 1919, that I last saw him alive on 11-29, 1919, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
23H 28
(Duration) 2 yrs. ... mos. ... ds.

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

(Signed) H. L. Ratty M. D.
11-30, 1919 (Address) Webb City, 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 1 yrs. 3 mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence Joplin Mo

19 PLACE OF BURIAL OR REMOVAL: Fairview Cem
DATE OF BURIAL: Dec 1, 1919

20 UNDERTAKER: Frank Sievers Co
ADDRESS: Joplin

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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.

1 PLACE OF DEATH

County .....

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

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

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....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.

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

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS