

WRITE PLAINLY WITH UNFADING INK

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

34067^a



County Iron

Township Dent

Registration District No. 393

File No. 34067^a

Village _____

Primary Registration District No. 5348

Registered No. _____

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Luke Crocker

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH Jan 2, 1906
(Month) (Day) (Year)

AGE 14 yrs. 10 mos. 21 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Iron co., Mo.

NAME OF FATHER George H. Crocker

BIRTHPLACE OF FATHER (City or town, State or foreign country) Iron co., Mo.

MAIDEN NAME OF MOTHER Alice Crocker

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iron co., Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Alice Crocker

(ADDRESS) Goodwater Mo

Filed Apr 8, 1921 Edyth Winters REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11 23, 1920
(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: Kicked through gate by vicious horse

(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 Goodwater Mo

DATE OF BURIAL 11 25, 1920

UNDERTAKER Ira Carl

ADDRESS Goodwater Mo

