

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.

JUN 27 1927

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

Crane  
Do not use this space  
14769

1. PLACE OF DEATH

County Greene Registration District No. 318  
Township Springfield Primary Registration District No. 2001  
City Springfield (No. 31 W. Cheanut St.)

File No. \_\_\_\_\_  
Registered No. 278  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence. No. 631 W. Cheanut St., \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2 - 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 3 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) \_\_\_\_\_

PARENTS

10. NAME OF FATHER Mo. Messieux

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) France

12. MAIDEN NAME OF MOTHER Thirga Howerton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) va.

14.

INFORMANT Mrs. H. M. Baker  
(Address) Springfield, Mo.

15.

FILED 5/6 1927 October 2nd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 6 1927

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 6, 1927, that I last saw him alive on May 6, 1927, and that death occurred, on the date stated above, at about 1:30 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

80% apoplexia  
74%  
arteriosclerosis  
anuria

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) J. J. Crane, M. D.  
576, 1927 (Address) 518 College St.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

National Cemetery May 9 1927  
20. UNDERTAKER L. W. Shingler & Co. ADDRESS 2246 Paul  
Springfield, Mo.

NO  
MILITARY  
STATE DEPARTMENT  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

WITH THE  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

STATE DEPARTMENT  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

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WASHINGTON, D. C.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Irene Registration District No. 318 File No. \_\_\_\_\_  
 Township Springfield Primary Registration District No. 2001 Registered No. 2878  
 City \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Wid  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
x70x3 4

**8. OCCUPATION OF DECEASED**

(a) Particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

PARENTS

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

14.

INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15.

FILE 576 17 October 1917  
 REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 6 1917

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, (that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

WRITE PLAINLY, WITH UNFADING INK---THIS IS A SUPPLEMENTARY RES.

N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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 COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-14769