

JUN 27 1927

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

Do not use this space.

14870 ✓

1. PLACE OF DEATH

County Harrison  
Township Fairview  
City (No. ....) St. .... Ward

Registration District No. 951  
Primary Registration District No. 3492

File No. ....  
Registered No. 13

2. FULL NAME

John A. Cromer  
(a) Residence, No. Deep Water, MO 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-6-1839

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
88 5 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Gen Housing  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Deep Water  
(STATE OR COUNTRY) MO

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT J. L. Cromer  
(Address) Deep Water, MO

15. FILED 5/6 1927 J. J. Russell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, That I attended deceased from Apr 29 - May 6 1927, to May 6 1927, that I last saw him alive on May 5 1927, and that death occurred, on the date stated above, at 2:30 A. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

132A  
162 nephritis  
12 A B

CONTRIBUTORY (SECONDARY) smoking  
(duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, .....

8 DID AN OPERATION PRECEDE DEATH, .....

WAS THERE AN AUTOPSY, .....

WHAT TEST CONFIRMED DIAGNOSIS, .....

(Signed) J. Russell M.D.  
5/6 1927 (Address) Deep Water

\*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

Jays Chapel May 8 1927

20. UNDERTAKER ADDRESS

Am. Burial Deep Water

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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County *Henry*

Registration District No. *351*

File No. ....

Township *Raymond*

Primary Registration District No. *5492*

Registered No. *12*

City .....

(No. ....)

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.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

*m*

4. COLOR OR RACE

*w*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*m*

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

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

7. AGE

YEARS

MONTHS

DAYS

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of 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)

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.

FILED *5/10 27* 19 *27*

REGISTRAR *J. B. Smith*

**MEDICAL CERTIFICATE OF DEATH**

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

17.

I HEREBY CERTIFY That I attended deceased from

....., 19....., 19..... that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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 *May 8/27*

WHICH 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 COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-14870