

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

Do not use this space.

645

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.

FEB 20 1928

1. PLACE OF DEATH

County Desha

Registration District No. 284

Township Franklin

Primary Registration District No. 468

City..... (No. 5405)

File No.

Registered No. 3

St. Ward)

2. FULL NAME

Margie Crocker

(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 ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (MARRIED)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-17-1905

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 Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Frank Townsend

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

12. MAIDEN NAME OF MOTHER Elizabeth Hughes

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

14. INFORMANT Frank Townsend Jr
(Address) Clarkton Mo

15. FILED..... 19.....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-30 1928

17. I HEREBY CERTIFY, That I attended deceased from 1-9, 1928, to 1-30, 1928 that I last saw her alive on 1-28, 1928 and that death occurred, on the date stated above, at 4.00 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Nephritis
115 A
130 109 B2
(duration)..... yrs. 6 mos. ds.
CONTRIBUTORY Tonsillitis -
(SECONDARY)
(duration)..... yrs. 20 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical + Chemical

(Signed) J. B. Stummey, M. D.

1-30, 1928 (Address) Clarkton Mo

*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 Caledonia Mo DATE OF BURIAL 1-31 1928

20. UNDERTAKER W. Hubbard ADDRESS Clarkton

PHYSICIAN should
be in very in

so that it may be
applied in carefully

DEATH
Every item of

**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 Jackson Registration District No. 284 File No. _____
 Township Greenbarn Primary Registration District No. 5403 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Margie Cracker
 (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 F 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) 6-17-1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
22 | 7 | 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse (duration) _____ yrs. _____ mos. _____ ds.
 (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) _____

FILED 1905 19 J. H. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30 19 28

17. I HEREBY CERTIFY that I attended deceased from _____, 19____, to _____, 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) _____ (duration) _____ yrs. _____ mos. _____ ds.

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 _____ 19____

20. UNDERTAKER ADDRESS _____

N. B. Information is to be supplied only if requested. AGE should be stated EXACTLY. PHYSICIAN'S name should state CAUSE OF DEATH in plain terms. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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