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

Do not use this space.

17838

1. PLACE OF DEATH
County: Miller
Township: Franklin
City: ..... (No. ..... St. ..... Ward)

Registration District No. 561
Primary Registration District No. 5756

File No. .....
Registered No. 45

2. FULL NAME: Dollie Leona Crum

(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: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): DEC 6. 1908

7. AGE: Years 19 | Months 4 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(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): Mo

PARENTS

10. NAME OF FATHER: Wm H. Crum
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Laura Brewer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo

14. INFORMANT: Wm H Crum
(Address): Rocky Mt. Mo

15. FILED 5-1 1928 Belle Haynes. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 1. 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to May 1, 1928, that I last saw her alive on May 1st, 1928, and that death occurred, on the date stated above, at 1 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tb.

31 238

..... (duration) 2 yrs. ..... mos. ..... ds.

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) E. C. Hallon, M. D
, 19 (Address) Eldon 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: Lamb Cemetery.
DATE OF BURIAL: 5-2 1928

20. UNDERTAKER: W. A. Phillips
ADDRESS: Eldon. Mo.

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.