

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

Do not use this space.

Walker

1. PLACE OF DEATH

County *Miller*
Township *Sadore*
City (No.) St. Ward

Registration District No. *561*
Primary Registration District No. *4230*
5755

File No. *27928*
Registered No. *27*
St. Ward

2. FULL NAME

William Alvin Crown

(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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 1 1876*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *50 11 12*

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) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio.*

10. NAME OF FATHER *Geo Crown*

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

12. MAIDEN NAME OF MOTHER *Amanda Fleming*

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

14. INFORMANT *Mrs Martha Crown* (Address) *Eldon Mo.*

15. FILED *9-10 1928* *Belle Haynes* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9/13 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 13* 19*28*, to *Aug 13* 19*28*, that I last saw him alive on *Aug 13* 19*28*, and that death occurred, on the date stated above, at *2 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental injuries caused by falling from scaffold. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

1928 (duration) yrs. mos. *6 hrs*

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) *G.D. Walker*, 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 *Doolay Cemetery* DATE OF BURIAL *9/15 1928*

20. UNDERTAKER *W.A. Phillips* ADDRESS *Eldon*

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.

