

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

Do not use this space

5061

1. PLACE OF DEATH

County Stoddard
 Township Bemis Mo
 City Bemis Mo (No.)

Registration District No. 836
 Primary Registration District No. 4507

File No.
 Registered No.
 St. Ward)

2. FULL NAME

Lucella Marcell Cressy

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

Female | White | Single

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

Single

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

11

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

2 | 10 | 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) —
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Bemis Mo

(STATE OR COUNTRY)

10. NAME OF FATHER

Paster Cressy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Bemis Mo

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mary Gourman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Stoddard Mo

(STATE OR COUNTRY)

14. INFORMANT

Mrs. Lucy Cressy
Bemis Mo

(Address)

15. FILED

1/19 1929
J. F. Huddle
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 19 29

17. I HEREBY CERTIFY, That I attended deceased from 1/9 1929, to 1/14 1929, and that I last saw h. alive on 1/14 1929, and that death occurred, on the date stated above, at 10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
107A

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptomatic

(Signed) J. F. Huddle, M. D.

, 19 29 (Address) Bemis 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

Bemis Mo

DATE OF BURIAL

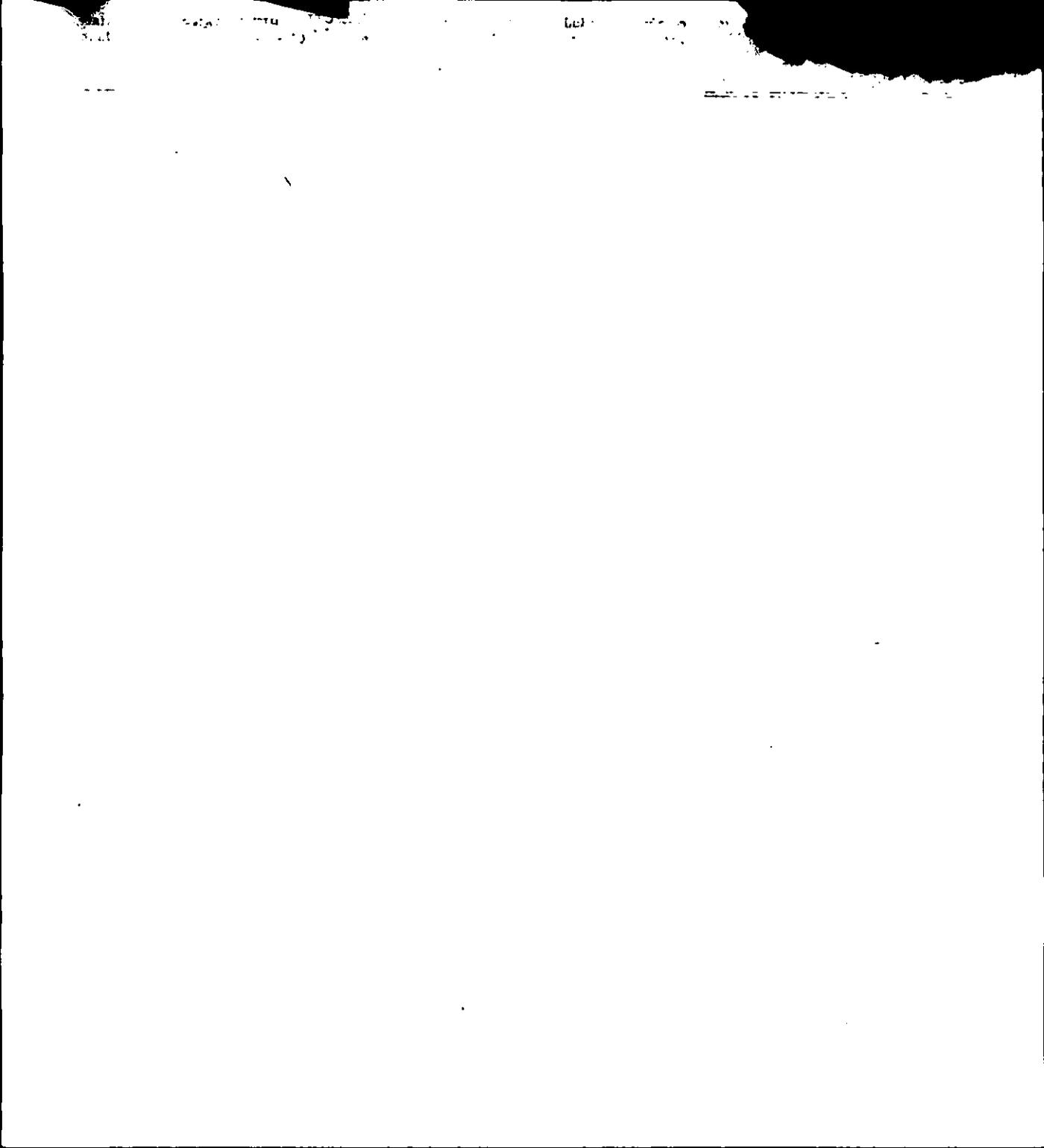
1/15 19 29

20. UNDERTAKER

Bemis Undertaking Co Bemis Mo

ADDRESS

103 1929
 PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.
 AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Stoddard Registration District No. 836 File No. _____
 Township _____ Primary Registration District No. 45-07 Registered No. _____
 City Bernie (No. _____) St. _____ Ward _____

2. FULL NAME Luelle M. Cready
 (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 S
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-4-1926

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>2</u>	<u>10</u>	<u>10</u>	

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1929
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and 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:
Bronchial pneumonia
of the pneumonic type
which followed
Measles or Whooping
 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.

14. INFORMANT _____ (Address) _____

15. FILED 1/19/29 C. J. Riddle REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____	DATE OF BURIAL _____
20. UNDERTAKER _____	ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. Exact statement of OCCUPATION is very important. A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY I.

SUPPLEMENTARY

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