

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Pruned

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

Do not use this space.

9145

1. PLACE OF DEATH

County *West*
 Township *Richland*
 City *Sikeston* (No.)

Registration District No. *871*
 Primary Registration District No. *6670*

File No. *36*
 Registered 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 *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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 9 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
62 11 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Carpenter*
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Crittendon Co.* (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Harvey Crowell*

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

12. MAIDEN NAME OF MOTHER *Nettie Drannon*

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

14. INFORMANT *Mrs. Estma Crowell* (Address) *Sikeston Mo.*

15. FILED *3/15/29* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 14 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 12*, 1929, to *Feb 14*, 1929, that I last saw him alive on *Feb 13*, 1929, and that death occurred, on the date stated above, at *8:50 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) *MI* (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) *Chas. Russell* M. D.

1929 (Address) *Sikeston 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 *Sikeston Mo.* DATE OF BURIAL *2/16 1929*

20. UNDERTAKER *J. H. ... Sikeston Mo.* ADDRESS

