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

Do not use this space.

12978

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 3531

Township ..... Primary Registration District No. ..... Registered No. .....

City St Louis (No. #4211 Westminster St. ..... Ward)

2. FULL NAME Barbara F. Cronk

(a) Residence. No. #4211 Westminster St. Ward 19 (If nonresident give city or town and State)
(Usual place of abode)

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: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Eugene S. Cronk

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 12, 1845

7. AGE: Years 83. Months 10. Days 8. 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): England.

PARENTS

10. NAME OF FATHER: Unknown Little
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): England.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): England.

14. INFORMANT: Mrs Crawford Duncan
(Address) #4211 Westminster

15. FILED ....., 19 ..... Registrar

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 20th 1929.

17. I HEREBY CERTIFY, That I attended deceased from 1/2/29, 19..., to 3/20/29, 19..., that I last saw her alive on 3/19/29, 19..., and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis acute
93A
119 (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY): Bronchitis, Asthma, non Tubercular (duration) ..... yrs. 3 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

3/20/29 (Signed) O. T. Falk, M. D
, 19 (Address) Beaumont Bldg

*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: Bellefontaine Cem
DATE OF BURIAL: 3-22, 1929.

20. UNDERTAKER: C. R. Lupton
ADDRESS: Olive Street #4449

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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Leave at office
at 10 A.M.
3720 Washington

4439 W. Pine