

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

Do not use this space.
Dr. Harrison
223716-15
File No. _____
Registered No. 90
St. _____ Ward _____

1. PLACE OF DEATH
County Andrain Registration District No. 26
Township Salt Spring Primary Registration District No. 5034
City Mexico Mo R.F.D. (No. _____) St. _____ Ward _____

2. FULL NAME Giles Andrew Thomas Crum
(a) Residence No. Mexico mo. R.F.D. 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 or (or) WIFE of Ellen Wayne Crum

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 3rd - 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
79 10 1

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) Franklin Co. Virginia

PARENTS
10. NAME OF FATHER Levin Riley Crum
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Lucy Kesler
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

14. INFORMANT Giles Crum
(Address) Mexico mo. R.F.D.

15. FILED July 6th 1929 Sra S. Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-4-29
17. I HEREBY CERTIFY That I attended deceased from 6-10-29 to 7-7-29 that I last saw him alive on 7-4-29, and that death occurred, on the date stated above, at _____ a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis -
92D
95B (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (Cardiomyopathy)
(duration) yrs. 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? no
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) J. H. Farnsworth M. D.
, 19 (Address) Mexico 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 Union Cemetery DATE OF BURIAL July 6-19 29
20. UNDERTAKER McPheters Bros. ADDRESS Mexico 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.

RECORDING DEATHS IS A PERMANENT RECORD

