

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

Do not use this space.

26570

**1. PLACE OF DEATH**

County..... Registration District No. *7811*  
 Township..... Primary Registration District No. *103*  
 City..... *St. Louis Mo. (No. 4500) Nichita Ave* St. .... Ward) (If nonresident, give city or town and State)

**2. FULL NAME**

(a) Residence. No. *4500 Nichita Ave.* St. *18* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 5-1846*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*83. 1. 23.*

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN).....**

(STATE OR COUNTRY) *Ohio*

PARENTS

10. NAME OF FATHER *James G. Crawford*

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

12. MAIDEN NAME OF MOTHER *Martha Ledowe*

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

**14.**

INFORMANT *Mrs. G. Stearns*  
 (Address) *4500 Nichita Ave.*

**15.**

FILED *29 1927* *May C. Starker*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July-28* 19*27*

17. I HEREBY CERTIFY, That I attended deceased from *now* *7-27*, 19*27*, to *July 28-* 19*27* that I last saw *her* alive on *July 28-* 19*27*, and that death occurred, on the date stated above, at *930 P.* m..

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Pneumonia  
Lobar.*

CONTRIBUTORY (SECONDARY) *1010* (duration) yrs. mos. ds. *3*

**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) *W. W. Stearns*, M. D.

*7-29-1927* (Address) *4559 Leadit*

\*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 DATE OF BURIAL

*Yellville Mo.* *7/31* 19*27*

20. UNDERTAKER ADDRESS

*Embrey and Co 4234 North 1st Ave*

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.

THIS IS A PERMANENT RECORD

