

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

Do not use this space.

27533

515

**1. PLACE OF DEATH**

County..... Harrison ..... Registration District No..... 334  
Township..... ..... Primary Registration District No..... H197  
City..... Bethany (No. ....) St. .... Ward)

File No.....  
Registered No.....  
St. .... Ward)

**2. FULL NAME**

May Ingle Crane  
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/15/1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 | 2 | 21 | =

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work..... Housework  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Williamsport  
(STATE OR COUNTRY) Pennsylvania

10. NAME OF FATHER Cline

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....  
(STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT W. G. Ingle  
(Address) Bethany, Mo.

15. FILED 8/16, 1929 W. H. Starned  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/6 1929  
17.

I HEREBY CERTIFY, That I attended deceased from X.....  
X....., 19....., to X....., 19.....  
that I last saw h. X alive on X....., 19....., and that death occurred, on the date stated above, at X.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apoplexy.  
Stroke  
CONTRIBUTORY (SECONDARY) U.A.I.  
(duration)..... yrs. .... mos. .... da.  
(duration)..... yrs. .... mos. .... da.

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) P. H. Beets-Borover  
Aug 8, 1929 (Address) Bethany 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 Pythian Cemetery DATE OF BURIAL 8/8 1929

20. UNDERTAKER S. M. Kaas ADDRESS Bethany, Mo.

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.

6-1-23-2-31-10

