

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

Do not use this space.

34640

**1. PLACE OF DEATH**

County Missouri  
Township Waverly  
City Newton

Registration District No. 655  
Primary Registration District No. 5822

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Regina Crowell

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX FM. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (or in the word) child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) xxxxx-1919

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
10      5      9

8. OCCUPATION OF DECEASED child

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

9. BIRTHPLACE (CITY OR TOWN) Chariton  
(STATE OR COUNTRY) MO

10. NAME OF FATHER Tom Crowell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dixon Co  
(STATE OR COUNTRY) Iowa

12. MAIDEN NAME OF MOTHER Marion

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

14. INFORMANT Tom Crowell  
(Address) Stell mo R 1

15. FILED 1915-29 Max P. Keeney  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) \_\_\_\_\_ 19\_\_\_\_

17. I HEREBY CERTIFY, That I attended deceased from 10/14, 1929 to 10/14, 1929 that I last saw her alive on 29/10/14, 1929 and that death occurred, on the date stated above, at \_\_\_\_\_ a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Spinal Meningitis

10 1/2 (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY (SECONDARY) MIA  
(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED home  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical symptoms  
(Signed) J. J. Roberts, M. D.  
(Address) Stell, 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 Luther cemetery DATE OF BURIAL 10-14-1929

20. UNDERTAKER Brown and Co ADDRESS Stell

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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