

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

Do not use this space.

37808

PLACE OF DEATH

County Miller
Township Saline
City _____ (No. _____, St. _____, Ward _____)

Registration District No. 561
Primary Registration District No. 5755

File No. _____
Registered No. 60

2. FULL NAME

Samuel Green Crum

(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. 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 OF (OR) WIFE OF Amanda Howard-Crum

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 6 11

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 - Owner.

9. BIRTHPLACE (CITY OR TOWN) Moniteau Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER William Crum
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Patrick Co. Virginia
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Matilda Harbor
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

14. INFORMANT George W Crum
(Address) Eldon, Mo.

15. FILED 11-26, 1929 Belle Haynes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1929, to Nov 24, 1929, that I last saw him... alive on Nov 28, 1929, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uraemic coma
131
132-13 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Intermittent nephritis
(SECONDARY) Chronic (duration) 2 yrs. _____ mos. _____ ds.

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) J. D. Walker, M. D.
. 19 (Address) Eldon 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 Olean Cem. Olean Mo DATE OF BURIAL 11-25-29

20. UNDERTAKER W.A. Phillips ADDRESS Eldon, 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.

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