

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

Do not use this space.

1868

1. PLACE OF DEATH

County Macou
Township Ten mile
City Macou (No. _____)

Registration District No. 1072
Primary Registration District No. 5716

File No. _____
Registered No. 2 St. _____ Ward _____

2. FULL NAME

Martha Ann Crow

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female

White

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF _____
(or) WIFE OF _____

Elewirth Crow

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

April 18 - 1883

7. AGE

YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hr. or _____ min.
<u>47</u>	<u>9</u>	<u>2</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

Mauroo. Ill

(STATE OR COUNTRY)

10. NAME OF FATHER

Austin B. Wagner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

12. MAIDEN NAME OF MOTHER

Malissie Self

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

14. INFORMANT

Elewirth Crow

(Address)

Macou mo

15. FILED

1-28 30 Gods notes

1930

REGISTRAR

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

Jan 20 1930

17. I HEREBY CERTIFY That I attended deceased from _____
March 29, 1929, to _____
June 20, 1930
that I last saw him _____ alive on _____
June 19, 1929 and that death occurred, on the date stated above, at _____
_____ a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary embolism
122A
111A
30 minutes

CONTRIBUTORY (SECONDARY)

Strangulated hernia
(duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

18. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) _____, M. D.

Chmical
T. J. Turner

, 19 _____

(Address) Macou, 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

DATE OF BURIAL

Mr. Tabor

Jan 22 1930

20. UNDERTAKER

ADDRESS

H. M. Gooding Atlanta Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

He

1929

PLASTIC PHYSICIAN'S
OCCUPATION IN

AGREEMENT

THESE ARE THE TERMS OF THE AGREEMENT

AND THE PARTIES HERETO

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Malcom Registration District No. 1072 File No.
Township Pen mile Primary Registration District No. 5716 Registered No. 2
City (No. St. Ward)

2. FULL NAME

Martha Ann Crow
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 18-1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 46 X 9 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(c) Name of employer

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 1930 Geo. Mays X REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) 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) , M. D.

, 19 (Address)

*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
19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
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.

SUPPLEMENTARY

8981-S