APR 28 1930

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

Do not use this space.

1. PLACE OF DEATH
County: Franklin — Registration District No.: 282 — File No.: 8236
Township: — Primary Registration District No.: 4166 — Registered No.: 10
City: Campbell (No. ..... St. ..... Ward)

2. FULL NAME: Thos. J. Crawford.
(a) Residence. No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 5-54

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	6	2	

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

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

PARENTS
10. NAME OF FATHER: Lindsay Crawford
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ala
12. MAIDEN NAME OF MOTHER: Eliza Dobbs
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Hiram Crawford
(Address): Campbell

15. FILED: 3/7, 1930 — E. W. Landess, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 7, 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 1925, to March 7, 1930, that I last saw him alive on March 7, 1930, and that death occurred, on the date stated above, at 8:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
Died suddenly (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? No
(Signed) M. L. Cone, M. D.
, 19 (Address) April 3 - 1930.

*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: Clear Cem. — DATE OF BURIAL: 3/9 1930

20. UNDERTAKER: E. W. Landess — ADDRESS: Camp

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.