

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

28801

1. PLACE OF DEATH

County Saline
Township Marshall
City (No.) St. Ward)

Registration District No. 796
Primary Registration District No. 6039

File No.
Registered No. 112

2. FULL NAME

James M. Crockett

(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

M

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

unknown

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

Sept 19 1880

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

18

11

2

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

9. BIRTHPLACE (CITY OR TOWN)

Mexico
(STATE OR COUNTRY) IND.

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

14.

INFORMANT (Address)

Kelley Crockett

15.

FILED

8-28-30 Mrs. John H. McQuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug 21 1930

17.

I HEREBY CERTIFY, That I attended deceased from Feb, 1930, to Aug 21, 1930. that I last saw last alive on Aug 21, 1930, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

typhoid
1868
1949
938

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY)

fractured hip

(duration) yrs. ? mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical

(Signed) [Signature], M. D.

Aug 22, 1931 (Address) Marshall

*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

salt Fork

DATE OF BURIAL

Aug 22 1930

20. UNDERTAKER

L. K. Hardner

ADDRESS

Marshall IND.

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.

1930

79

**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 Saline
Township Marshall
City (No. _____) (St. _____) (Ward _____)

Registration District No. 796
Primary Registration District No. 6039

File No. _____
Registered No. 112

2. FULL NAME

James M. Crockett

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 19 - 18 50

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 | 11 | 2

8. OCCUPATION OF DECEASED

(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) _____ (STATE OR COUNTRY) _____

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 8-28, 1930 Mrs. John H. McQuinn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 21 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
fall on concrete floor

CONTRIBUTORY (SECONDARY) Fractured hip
He was walking on

18. WHERE WAS DISEASE CONTRACTED crutches
IF NOT AT PLACE OF DEATH, stumbled from
DATE OF _____
unsteadiness
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
1925
WAS THERE AN AUTOPSY? refracting the
WHAT TEST CONFIRMED DIAGNOSIS? same bone
(Signed) after which apoplexy, 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 _____

20. UNDERTAKER _____ ADDRESS _____

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

SUPPLEMENTARY

S-28801