

OCT 28 1930

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

Do not use this space.

29618

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. 29618  
Township Washington Primary Registration District No. 2001 Registered No. 685  
City Springfield St. Washington (Ward)

2. FULL NAME

(a) Residence. No. 1951 Wash. Ave. St. Washington Ward. Washington  
(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

2 MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

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

Male Colored Single

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

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

about 58

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 2101 103

(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)

Tenn

10. NAME OF FATHER

Albert Crocker

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Shallowford

12. MAIDEN NAME OF MOTHER

Caroline Rice

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14. INFORMANT

Lige E. Peague  
(Address) 1951 Wash. Ave

15. FILED

9-11-30  
For Sharp  
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 9th 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug. 31st 1930 to Sept 9th 1930 that I last saw him alive on Sept 9th 1930, and that death occurred, on the date stated above, at 2 p. m.

18. THE CAUSE OF DEATH WAS AS FOLLOWS:  
Basilar Fracture of Skull  
Resulting from which Ran  
Over Embankment Turning  
Over in Springfield mo 9  
CONTRIBUTORY Demerol  
(SECONDARY) (duration) 9 yrs. 9 mos. 9 da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: Accident near Belle Park

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

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) H. E. Hunt, H. D.

9/10, 1930 (Address) 365 Branch Hospital, 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 Hazelwood DATE OF BURIAL Sept 11 1930

20. UNDERTAKER H. P. Campbell ADDRESS 809 Wash

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

... should be stated EXACTLY. PHYSICIAN'S ...  
... that it may be reported ...  
... in plain ...

**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 Greene  
Towship Springfield  
City Springfield (No. ....) St. .... Ward)

Registration District No. 318  
Primary Registration District No. 2001

File No. ....  
Registered No. 683-

**2. FULL NAME**

(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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (circle the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

**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

9-11-30 John Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Basilar fracture of skull driving force while man over embankment in Springfield, Mo. (duration) .... yrs. .... mos. .... ds. CONTRIBUTORY BECAME KNIGHTED (SECONDARY) for control of car (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) ..... 21<sup>3</sup> ....., 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

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

SUPPLEMENTARY

1880

1930  
29618