

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

NOV 28 1930

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

Do not use this space.

1. PLACE OF DEATH

County Stoddard  
Township Rich  
City (No. ....) (Name .....) (Ward .....)

Registration District No. 834  
Primary Registration District No. 6097

File No. 35107  
Registered No. 32  
St. .... Ward .....

2. FULL NAME

L. P. Crews

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

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

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

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1930 to Oct. 16, 1930 (that I last saw him) alive on Oct. 16, 1930, and that death occurred, on the date stated above, at 3:45 P.M.

male White Married

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

Polly Crews

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 29, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 54 8 29

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

General arteriosclerosis  
with cerebral artery  
thrombosis

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Teaching

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

(duration) yrs. mos. da. 2 yrs

CONTRIBUTORY (SECONDARY)

none

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis, Mo.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH

DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. J. Humphrey, M.D.

10-21-1930 (Address) Summit, 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.

14. INFORMANT

(Address)

Polly Crews  
1222 1/2 St. Paul

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Leora Cem., Mo.

10-17-1930

20. UNDERTAKER

ADDRESS

Gloyd S. Morgan,

Advance, Mo.

FILED 10-21-1930

W. J. Humphrey  
REGISTRAR



**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 Stoddard Registration District No. 834 File No. \_\_\_\_\_  
 Township Pike Primary Registration District No. 6097 Registered No. 325  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

L. R. Crews

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

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 \_\_\_\_\_.

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Gunshot wound inflicted, homicide  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 \_\_\_\_\_

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: \_\_\_\_\_

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

WAS THERE AN AUTOPSY? \_\_\_\_\_

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

(Signed) \_\_\_\_\_, M. D. \_\_\_\_\_, 19\_\_\_\_ (Address)

14. INFORMANT (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

15. FILED 12-10-1930 A. M. Kearney REGISTRAR

20. UNDERTAKER ADDRESS

**SUPPLEMENTARY**

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

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

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