

NOV 3 1938

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

Do not use this space.

File No. **35121**
Registered No. **38**
St. _____ Ward _____

1. PLACE OF DEATH

County Stoddard Registration District No. 840
Township Duck Creek Primary Registration District No. 6102
City Paris, Mo (No. _____) St. _____ Ward _____

2. FULL NAME Lillian Evelyn Crabb

(a) Residence. No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 9 - 1918

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
12 0 25

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) Cape Gir. Mo

PARENTS
10. NAME OF FATHER Walter O Crabb
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Paris Mo
12. MAIDEN NAME OF MOTHER Lulla Fay
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Sabitha Kinnaman
(Address) Paris Mo

15. FILED Oct 6 1938 E L Hope REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 4 1938

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1938 to Oct 4 1938 that I last saw him alive on Oct 4 1938 and that death occurred, on the date stated above, at 11 00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Typhoid Fever
(duration) _____ yrs. _____ mos. 20 ds.
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? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) E. L. Hope, M. D.
Oct 6 1938 (Address) Paris 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 Crown Cemetery DATE OF BURIAL Oct 6 1938

20. UNDERTAKER Hickman White Store Co ADDRESS Paris Mo

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

