

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

Do not use this space.

11057

1. PLACE OF DEATH

County Cass
Township North Creek
City _____ (No. _____)

Registration District No. 670
Primary Registration District No. 589.6

File No. _____
Registered No. 7
St. _____ Ward _____

2. FULL NAME

James Marshall Crabtree

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 17, 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 8 17

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). Tiller of Soil
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cooper Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER James Crabtree

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

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't Know
(STATE OR COUNTRY)

14. INFORMANT Marion M. Walter
(Address) Longwood Mo.

15. FILED 4-3, 1931 Flossie Ferguson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 4 - 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27 - 1931 to Mar. 3 - 1931
that I last saw him alive on Mar. 3 - 1931, and that death occurred, on the date stated above, at 4:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubercular Pneumonia
108
92A

CONTRIBUTORY (SECONDARY) Med. Insufficiency of
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. D. Russell, M. D.
(Address) Longwood Mo.

*State the DISEASE CAUSING DEATH, or 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

Union Cemetery

DATE OF BURIAL

Mar. 1931

20. UNDERTAKER

R. C. Carter Longwood Mo.

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.

APR 25 1931

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 "exact state"

state
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**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 Pettis Registration District No. 670 File No.
 Township Heath Creek Primary Registration District No. 3-896 Registered No. 7
 City (No.) St. Ward

2. FULL NAME James Marshall Crabtree
 (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) wid

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)

PARENTS

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 4 19 31

17. I HEREBY CERTIFY, That I attended deceased from to
 that I last saw h. alone on 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) 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..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....

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

FILED 4-3 19 31 Flossie Ferguson
 REGISTRAR

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

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