

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

Do not use this space.

3426

1. PLACE OF DEATH

County Shelby
 Township Shelby
 City Shelbyville (No. _____) St. _____ Ward _____

Registration District No. 831
 Primary Registration District No. 4504

File No. _____
 Registered No. _____

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 18 1837

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
95 | 0 | 8 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (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) Ralls Co. Mo

10. NAME OF FATHER Mrs. Priest

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Barth, Pa

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) Mrs. Fannie Armstrong
Shelbyville, Mo.

15. FILED Jan 15 1932 Emmett A. Houser REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 14 1932

17. I HEREBY CERTIFY, That I attended deceased from _____ 1932 to Jan. 14 1932 that I last saw him alive on Jan. 6 1932 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Septic Gall Bladder
Cardiac insufficiency
 (duration) 45 yrs. 1 mos. 0 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? do not know

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical
 (Signed) D. L. Thompson M. D.
 _____ 19 (Address) Bethel 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 DATE OF BURIAL
I.O.O.F. Cemetery Jan-16-1932

20. UNDERTAKER ADDRESS
J. W. Thompson Son Shelbyville, 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.

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32
95

