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

Do not use this space.

7673

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. .....

City St. Louis Mo. (No. ..... St. ..... Ward)

File No. .....

Registered No. 1633

2. FULL NAME Hattie Crawford

(a) Residence. No. 3324 Franklin Rear, 21 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-2-1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	24	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Rankin County
(STATE OR COUNTRY) Miss

PARENTS

10. NAME OF FATHER Will Crawford

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

12. MAIDEN NAME OF MOTHER Angie Taylor

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

14. INFORMANT Ida Rook rear
(Address) 3324 a Franklin

15. FILED FEB 17 1933 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH 1933

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1932

17. I HEREBY CERTIFY, That I attended deceased from 2-14, 1933, to 2-14, 1933 that I last saw her alive on 2-14, 1933, and that death occurred, on the date stated above, at 8:50 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108 (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) 108 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) [signature], M. D.

2/15, 1933 (Address) 822 a N. Jefferson

*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
Father Dickson	Feb 17 1933
20. UNDERTAKER	**ADDRESS**
E. M. Tyler	3029 Caroline

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

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..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis (No. ....., ... St. ..... Ward)

File No. .....

Registered No. 1633

2. FULL NAME Hattie Crawford

(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 F

4. COLOR OR RACE B

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 2 - 1908

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.
24	7	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

FATHER

13. NAME .....

14. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME .....

16. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

17. INFORMANT ..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19....

19. UNDERTAKER ..... (ADDRESS)

20. FILED MAY 8 1933 J. F. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 14 X. 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Other contributory causes of importance:	

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

.....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

(Address) .....

SUPPLEMENTARY

S-7673