

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

Do not use this space.

26139

1. PLACE OF DEATH

39 County Greene
Township Republic
City Republic, Mo. (No. _____)

Registration District No. 317
Primary Registration District No. 5436

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

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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or wife of) Lonie Mae Carroll
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 2, 1874
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
58 10 8

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) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

10. NAME OF FATHER M. L. Crum
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Nancy Rambo
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

14. INFORMANT Mrs. Felix Crum
(Address) Republic, Mo.

15. FILED 8/11, 1933 W. W. Shover
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2) 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 1933
17. I HEREBY CERTIFY, That I attended deceased from April 2, 1933 to Aug 10, 1933
that I last saw him alive on Aug 10, 1933 and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Asthma
130
110
CONTRIBUTORY bronchial degeneration
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.
(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) H. E. Mitchell, M. D.
, 19 (Address) Republic, 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 Lindsey Chapel Cemetery DATE OF BURIAL 8/11 1933
20. UNDERTAKER R. E. Thurman & Co. ADDRESS Republic, 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. SEP 26 1933

