

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

Do not use this space.

42321

104
JAN 26 1933

1. **PLACE OF DEATH**
 County St. Louis Registration District No. 845
 Township James Primary Registration District No. 6109
 City _____ (No. _____) St. _____ (Ward _____)

2. **FULL NAME** Unnamed
 (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

MEDICAL CERTIFICATE OF DEATH

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) Dec 24 1933

| | | | | |
|---------------|--------------|---------------|-------------|---|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
| | — | — | — | 12 |

8. **OCCUPATION OF DECEASED**
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

16. **DATE OF DEATH** (MONTH, DAY AND YEAR) Dec 25 1933

17. I HEREBY CERTIFY, That I attended deceased from 12/24/33 19____ to Dec 25/33 19____ that I last saw him alive on Dec 24/1933, and that death occurred, on the date stated above, at 9/A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature birth at 8th mo.

159 (duration) yrs. mos. ds.
160 forceps delivery (possible) (duration) yrs. mos. ds.

18. **WHERE WAS DISEASE CONTRACTED**
 IF NOT AT PLACE OF DEATH _____

19. **DID AN OPERATION PRECEDE DEATH?** _____ DATE OF _____

20. **WAS THERE AN AUTOPSY?** _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) L. S. Shennate M. D.
12/30/1933 (Address) Reeds Spring 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.

9. **BIRTHPLACE** (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

PARENTS

10. **NAME OF FATHER** Arthur Crabtree

11. **BIRTHPLACE OF FATHER** (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

12. **MAIDEN NAME OF MOTHER** Viola Dickerson

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

14. **INFORMANT** Arthur Crabtree
 (Address) Reeds Spring Mo

15. **FILED** 12/30 1933 L. S. Shennate
 REGISTRAR

19. **PLACE OF BURIAL, CREMATION, OR REMOVAL** Yocum Pond Cemetery **DATE OF BURIAL** Dec 25 1933

20. **UNDERTAKER** Mrs. Hettie Stults **ADDRESS** Reeds Spring Mo

X. 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.

