

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

Do not use this space.

403

1. PLACE OF DEATH
 County Cape Girardeau Registration District No. 124
 Township Whitewater Primary Registration District No. 5180
 City North Miller St. _____ Ward _____

2. FULL NAME Ferry Lee Crossnoe
 (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 M. 4. COLOR OR RACE W. 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) Sept 23, 1932

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>1</u>	<u>3</u>	<u>14</u>	

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

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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 9, 1934

22. I HEREBY CERTIFY That I attended deceased from Jan 7, 1934 to Jan 9, 1934
 I last saw him alive on Jan 8, 1934. Death is said to have occurred on the date stated above, at 4 P.M.
 The principal cause of death and related causes of importance were as follows:
Dysentery
 Date of onset Jan 7, 1934

Other contributory causes of importance: none

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Miller Mo.

13. NAME Gely Crossnoe

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Gir Co. Mo.

15. MAIDEN NAME Lidia R. Proffer

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

17. INFORMANT Gely Crossnoe (ADDRESS) Miller Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Heblish cemetery DATE Jan 9, 1934

19. UNDERTAKER McComb & Co (ADDRESS) Jackson Mo.

20. FILED 1-10-34 D. G. Seiber Registrar.

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? No
 If so, specify _____
 (Signed) D. G. Seiber, M. D.
 (Address) Jackson 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.

