

SEP 27 1938

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

29625  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Oregon Registration District No. 631  
 (b) Township Hoshkoning Primary Registration District No. 4381 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Laura Crow  
 (a) Residence, No. 15 Year - St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OF RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm D. Crow  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar - 6 - 1857  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 86. 5 24  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Domestic  
 9. Industry or business in which work was done, as 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) Markspoon  
 FATHER 13. NAME Faubert Bink  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
 MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 17. INFORMANT (ADDRESS) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Wayside Cem 9/1-3-38  
 19. FUNERAL DIRECTOR (ADDRESS) Wm. H. ...  
 20. FILED Sept 27 1938 Seventy ... Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-1-38, 1938  
 22. I HEREBY CERTIFY, That I attended deceased from 8/29, 1938, to 9/1, 1938  
 I last saw him alive on 8/31, 1937 Death is said to have occurred on the date stated above, at 10:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Acute Cardiac  
Dehydration  
 Date of onset 8/27/38  
 Other contributory causes of importance: 130  
Scrubby x  
Dysentery  
 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) Maurice Hampton, M. D.  
 (Address) West Plains, Mo

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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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Oregon Registration District No. 631  
 (b) Township..... Primary Registration District No. 4381 Registered No.....  
 (c) City Keshkonong Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Louisa Crow

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-1-1938

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 6 1938

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
86 5 24

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....  
 9. Industry or business in which work was done, as saw mill, bank, etc.....  
 10. Date deceased last worked at this occupation (month and year).....  
 11. Total time (years) spent in this occupation.....

Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

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

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

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

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

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

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

17. INFORMANT (ADDRESS) Les Crow Thayer mo

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

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Manner of injury..... Nature of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

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

20. FILE Sept 8<sup>th</sup> 38 Courtenay Richards Local Registrar

If so, specify (Signed) Maurice Thompson M. D. (Address) West Plains

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important. So that it may be properly classified.

S-29625