

REC'D FEB 6 1939

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

Do not use this space.

3220

1. PLACE OF DEATH

72 County *New Madrid*
Township *St Louis*
City *St. Pleasant* (No. *1*)

Registration District No. *604*
Primary Registration District No. *4-3-5-80*
4310

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence No. St. Ward.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. *21* ds. *10* How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M.* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 19 1939*

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

22. I HEREBY CERTIFY That I attended deceased from *Jan 17 1939* to *Jan 19 1939*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 9 1937*

I last saw him alive on *Jan 18 1939* Death is said to have occurred on the date stated above, at *4 P.* m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *21 10*

The principal cause of death and related causes of importance were as follows:
Meningitis
Post cerebral spinal

OCCUPATION 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

Date of onset *Jan 15*
Other contributory causes of importance:
Chills meningitis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Pleasant Mo*

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

FATHER 13. NAME *Robert M. Cready*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Pleasant Mo*

MOTHER 15. MAIDEN NAME *Estelle H. Warner*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Syersburg Mo*

17. INFORMANT (ADDRESS) *Robert M. Cready*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Ignace* DATE *Jan. 20 1939*

19. UNDERTAKER (ADDRESS) *Richard Ruff Co New Madrid Mo*

20. FILED *1/30 1939* *Wm O'Bannon Registrar*

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) *Dr. Frank R. ...* M. D.
Frank R. ... (Address)

532

COPY OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

57

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3226
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 604
 (b) Township..... Primary Registration District No. 4360 Registered No.....
 (c) City Point Pleasant (d) 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

(a) Residence, No. Jerry Mc Crady SU (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 M 4. COLOR OR RACE W 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
21 10

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

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19 1937

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:

meningitis
Berman #
Otitis
 Date of onset 89a

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) Claude Mc Raven, M. D.
marston (Address) ms

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

SUPPLEMENTARY

