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.

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

DEC'D APR 6 1939

9895
Do not use this space.

1. PLACE OF DEATH
(a) County Oldrum 2 Registration District No. 921
(b) Township Cuivro 1 Primary Registration District No. 4557 Registered No.
(c) City Farber (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 Walter J Crow
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (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) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Maggie L Crow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28 1861
7. AGE YEARS 78 MONTHS DAYS 22 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Post Master
9. Industry or business in which work was done, as saw mill, bank, etc. Farber P.O.
10. Date deceased last worked at this occupation (month and year) Jan. 28-1939
11. Total time (years) spent in this occupation 26-Yrs.

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

FATHER
13. NAME Jacob Crow
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER
15. MAIDEN NAME Katherine Shaw
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) John Crow
18. BURIAL, CREMATION, OR REMOVAL
PLACE Farber DATE 3-23 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W S Wales
20. FILED Mar 26 1939 Wm Mag Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ~~Feb~~ 22, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1939 to March 22, 1939
I last saw him alive on March 21, 1939 Death is said to have occurred on the date stated above, at 1.40 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypostatic Lobar Pneumonia	3-20-39

Other contributory causes of importance:
Paralysis of left side, due to Apoplexy Jan, 26-39

Name of operation Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

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) W. K. McCall, M. D.
28 (Address) Laddonia Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-39-477
Date Filed MAR 28 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed Wm. B. Wales

Licensed Embalmer No. 3321

P. O. Address Vandalia Mo

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

If this body is not embalmed, above space should be left blank.