

REC'D JUL 19 1939

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

23142
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois 2 Registration District No. 779
 (b) Township Madison 1 Primary Registration District No. 6024W
 (c) City Osage Mo (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. 453 Osage Mo 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 Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John P. Williams
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 3, 1854
 7. AGE YEARS 84 MONTHS 8 DAYS 24 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. house work
 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) Blue Run, Missouri

FATHER 13. NAME Anderson Crawford

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

MOTHER 15. MAIDEN NAME Wacey Crawford

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT (ADDRESS) Mattie Craig Osage Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mitchell DATE 6-28-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. J. Dyer Osage Mo

20. FILED 7-10-39 W. Blackworth Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-26-1939

22. I HEREBY CERTIFY, That I attended deceased from 6-12-39, 1939, to 6-26-39, 1939

I last saw her alive on 6-20-39. Death is said to have occurred on the date stated above, at 4:30 pm.

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

Bronchopneumia

Date of onset 6-25-39

Other contributory causes of importance: Fracture h hip 6-12-39

Name of operation none 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? no Date of injury 6-12-39

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

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

Manner of injury fall

Nature of injury one surg neck h femur

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Harold O. Bache, M. D.

(Address) Osage Mo

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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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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.....

Licensed Embalmer No.....

P. O. Address.....

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.