REC'D SEP 19 1939

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

29690
Do not use this space.

1. PLACE OF DEATH
(a) County Marion Registration District No. 547
(b) Township 6 Mason Primary Registration District No. 3029 Registered No. 253
(c) City Hannibal (d) Street No. 1014 Vermont 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 600 Nelson Crow
(a) Residence, No. 1014 Vermont 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 Male
4. COLOR OR RACE Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Crow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept
7. AGE about 65 YEARS MONTHS DAYS If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Jabeer
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) Pike Co Mo

FATHER
13. NAME Joe Crow
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Hester Crow
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Mrs Anna Crow 1014 Vermont St
18. BURIAL, CREMATION, OR REMOVAL
PLACE Robinson DATE 8-23 1939
19. FUNERAL DIRECTOR (ADDRESS) Geo E Roberts Hannibal Mo
20. FILED Aug 30 1939 W C Fisher
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-20 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept 4th 1939, to Aug 20 1939
I last saw h.....alive on Aug 20 1939. Death is said to have occurred on the date stated above, at 8.50 P.M.
The principal cause of death and related causes of importance were as follows:

Mitral Insufficiency

Date of onset

Other contributory causes of importance: 92 W

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) H P McMechen, M. D.
48 (Address) Hannibal Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

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 wit the above constitutes grounds for revocation of license.)