

REC'D SEP 7 1939

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

30398

Do not use this space.

103
1. PLACE OF DEATH

(a) County Stoddard Registration District No. 839
 (b) Township Freshland Primary Registration District No. 6101 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 Bonnie Sue Cravell

(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

3. SEX female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14 - 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 6

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) Stoddard Co. Mo13. NAME Bonnie Sue Cravell14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Penn.15. MAIDEN NAME Evelyn Latham16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Mathews Mo.17. INFORMANT (ADDRESS) Jack Cravell
father18. BURIAL, CREMATION, OR REMOVAL PLACE Mathews, Mo. DATE 8-19-3919. FUNERAL DIRECTOR (NAME) (ADDRESS) H. J. Welch
Sikeston, Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw her 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:

_____ Date of onset _____

 Other contributory causes of importance: Asphyxiation

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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? _____ If so, specify _____

(Signed) Per Hearne, Acting Registrar M. D.75 (Address) Bloomfield, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms. Exact statement of OCCUPATION is very important. PHYSICIANS should state cause of death in plain terms. Exact statement of OCCUPATION is very important.

182

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

RECEIVED

District Health Officer No. 2
District File Number 939-182
Date Filed 9-6

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 do with the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30398

Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard Registration District No. 839
(b) Township Richland Primary Registration District No. 6101 Registered No.
(c) City (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 Bonnie Sue Crowell
(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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8
(Write the word)

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. or min.
1 5

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) 8-19-1939

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:

Other contributor causes of importance:
Suffocation
N.M.D.
Date of onset

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? suicide Date of injury 8-19-1939
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
at home in Richland Township
Manner of injury
Nature of injury asphyxiation

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify:
(Signed) Bess Kearney, act. Cas.
(Address) Bloomfield, Mo.

SUPPLEMENTARY

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

S-30398