

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.

RECEIVED OCT 13 1939

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

33701
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 834
 (b) Township Wike Primary Registration District No. 10097 Registered No. 32
 (c) City New Advance, Mo. (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

(a) Residence, No. 621 Rollie Crews St.
near Advance, Mo. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

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

22. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1939, to Feb. 26, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 17, 1899

I first saw her alive on Feb. 16, 1939 Death is said to have occurred on the date stated above, at 6:45 P.M.

7. AGE YEARS 59 MONTHS 3 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.

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

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 _____

Congestive Heart Failure Date of onset _____
 Other contributory causes of importance: Very bad atherosclerosis, valvular lesions, nephritis, enlarged heart, & mental depression

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

FATHER 13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

MOTHER 15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Versie Crews (ADDRESS) Alton, Illinois

18. BURIAL, CREMATION, OR REMOVAL PLACE Deer Cemetery DATE Feb 27, 1939

19. FUNERAL DIRECTOR (NAME) Sp. J. Morgan (ADDRESS) Advance, Mo.

20. FILED Oct 1, 1939 D. S. M. Lee Local Registrar.

Name of operation _____ Date of _____

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) Edwin B. Mathias, M.D. (Address) Advance, Mo.

9/2/22

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES
10000 NORTH MOPAC EXPRESSWAY
AUSTIN, TEXAS 78759

RECEIVED
District Health Officer No. 2
District File Number 1039-257
Date Filed 10-9

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

337017
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 834
 (b) Township Paris Primary Registration District No. 6097 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 Pollie Crews
 (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, (write the word) wid

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.
	<u>59</u>	<u>3</u>	<u>9</u>	

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-26, 1937

22. I HEREBY CERTIFY, That I attended deceased from 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:
Congestive Heart failure Date of onset
(Diphtheria chronic) p. 1
 Other contributory causes of importance:
They had organic valvular lesion, nephritis, enlarged liver and marked degeneration
 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 Edwin Masters M. D. (Signed)
 (Address) Adverse mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

