

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

*Du Stephens*  
12525

1. PLACE OF DEATH

County *Henry* Registration District No. *350-353* File No. *53*  
Township \_\_\_\_\_ Primary Registration District No. *3018* Registered No. \_\_\_\_\_  
City *Clinton* (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Floyd Crothorn*  
(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. - mos. - da. How long in U.S., if of foreign birth? *not in* yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *✓* (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 6, 1903*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*15 11 5*

8. OCCUPATION OF DECEASED *boy*  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) *Clinton Mo.*  
(STATE OR COUNTRY) *Bates Co. Mo.*

10. NAME OF FATHER *Wm. Crothorn*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Benton Co. Mo.*  
(STATE OR COUNTRY) *Benton Co. Mo.*

12. MAIDEN NAME OF MOTHER *Martha Ingram*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Benton Co.*  
(STATE OR COUNTRY) *Benton Co., Mo.*

14. INFORMANT *Mrs. Wm Crothorn*  
(Address) *Clinton Mo.*

15. FILED *4/30 1923* *E. C. Geelor*  
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 9<sup>th</sup> 1923*

17. I HEREBY CERTIFY, That I attended deceased from *11 A.M.* to *9 P.M.* to \_\_\_\_\_ 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at *Clinton Mo.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Poisoned Excessive Vomiting & exhaustion Eating deceased corn & candy from the stomach.*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY *Gastritis*  
(SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED *at home*  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? *No* DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) *D. Stephens* M. D.  
, 19\_\_\_\_ (Address) *Clinton Mo.*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Englewood* DATE OF BURIAL *4/21 1923*

20. UNDERTAKER *Sims-Wilkins* ADDRESS *Clinton, Mo.*

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.

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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.

1. PLACE OF DEATH  
 County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No.....  
 City..... (No.)..... St..... Ward.....

2. FULL NAME  
 (a) Residence, No..... St..... Ward.....  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS			
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)	
3A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY AND YEAR)			
7. AGE	YEARS	MONTHS	DAYS
			If less than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED			
(a) Trade, profession, or particular kind of work			
(b) General nature of industry, business, or establishment in which employed (or employer)			
(c) Name of employer			
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
10. NAME OF FATHER			
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)			
12. MAIDEN NAME OF MOTHER			
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)			
14. INFORMANT (Address)			
15. FILED....., 19.....			REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
 ..... (duration) ..... yrs. .... mo. .... da.  
 ..... (duration) ..... yrs. .... mo. .... da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH..... DATE OF.....  
 DID AN OPERATION PRECEDE DEATH.....  
 WAS THERE AN AUTOPSY.....  
 WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed)....., M. D.  
 , 19 (Address)

\*State the Disease Causing Death, or in death from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
 ADDRESS 19.....

20. UNDERTAKER