MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Cape Girardeau

Township Liberty
or
Village
or
City (NO. , St.: Ward)

Registration District No. 130 File No. 38577

Primary Registration District No. 5181 Registered No. 15

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Lora Lee Crump

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: Nov (Month) 4 (Day), 1908 (Year)

AGE: 4 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country): Whitewater Mo

PARENTS
NAME OF FATHER: Allie Crump
BIRTHPLACE OF FATHER (City or town, State or foreign country): Whitewater Mo
MAIDEN NAME OF MOTHER: Gusta Shafer
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Bismark Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allie Crump

(ADDRESS) Whitewater Mo

Filed Dec 15, 1912. A. M. Murphy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 15 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 13, 1912, to Dec 15, 1912, that I last saw her alive on Dec 15, 1912, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Diphtheria

10

(Duration) yrs. mos. 7 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) P. M. Finney M. D.

Dec 16, 1912 (Address) Whitewater

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Brodeville Cemetery

DATE OF BURIAL: Dec. 15 1912

UNDERTAKER: J. M. Slagle

ADDRESS: Whitewater Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward) [If deat hospital give its of street

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day) ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day

I HEREBY CERTIFY, that I attended dec

....., 191...., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos.

(Signed) .....

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent C (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS T RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE O
UNDERTAKER	ADDRES

FROM

STATE BOARD OF HEALTH

Bureau of Vital Statistics

V. S. FORM

JEFFERS

STATE