LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County: Lawrence
Township: Pierce
or
Village:
or
City: ~~Monett~~ (NO. ..... St.: ..... Ward)

Registration District No. 471 File No. 3 7617
Primary Registration District No. 5634 Registered No. 26

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

2 FULL NAME: Willis Russell Crossland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June 15, 1919 (Month) (Day) (Year)

7 AGE: 0 yrs. 8 mos. 11 ds.
If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Lawrence Co Mo

PARENTS
10 NAME OF FATHER: Oliver Wesley Crossland
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Texas Co Mo
12 MAIDEN NAME OF MOTHER: Columbia Eagle
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Lawrence Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): O W Crossland
(Address): Monett Mo

15
7 Filed 2-27, 1920 J. A. Drimbra Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 26, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 16, 1920, to Feb 26, 1920, that I last saw h. alive on Feb 25, 1920, and that death occurred, on the date stated above, at 6 10 a. m.

The CAUSE OF DEATH* was as follows:
Influenza
IIA
10
(Duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary): Bronchial Pneumonia
(Duration) ..... yrs. ..... mos. 7 ds.
(Signed): J. M. Carnell M. D.
Feb 27, 1920 (Address): Seligman Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Eventide
DATE OF BURIAL: 2/27/20, 191

20 UNDERTAKER: R. McCullough
ADDRESS: Monett Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

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

that I last saw h.....alive on....., 191.....,

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed).....M. D.

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

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

18 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 pl[illegible] of death?.....

Former [illegible] usual [illegible] .....

19 F[illegible] BURIAL OR REMOVAL

DATE OF BURIAL

..... 191

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im[illegible]