

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City **St. Louis** (No. **Peoples Hosp.**)

**22779**

File No.....  
 Registered No. **6188**  
 St. .... Ward)

**2. FULL NAME**

**James J. Crawford**  
 (a) Residence No. **1728 N. Whittier** St., **11** Ward.

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not Known 1887**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**abt 42 Not Known**

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Miss.**

10. NAME OF FATHER **Robert Crawford**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Miss.**

12. MAIDEN NAME OF MOTHER **Amelia Crawford**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Miss.**

14. INFORMANT (Address) **Levi W. Crawford Okolona Miss.**

15. JUN - 8 1929 **Wm C. Fairley** REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6/6 1929**

17. I HEREBY CERTIFY, That I attended deceased from **6-2-29** to **6-4-29**, 19**29**, that I last saw him alive on **6-4-29**, and that death occurred, on the date stated above, at **11:19 AM**.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Septic Peritonitis**

**12 1/2** (duration) yrs. mos. **3** da.

CONTRIBUTORY (SECONDARY) **Ruptured appendix** (duration) yrs. mos. **2 1/2** da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **6-3-29**

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Lakeston**  
 (Signed) **P. H. Farmer**, M. D.  
 (Address) **4064 Olive**

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Okolona Miss.** DATE OF BURIAL **6/9 1929**

20. UNDERTAKER **R. M. C. Green** ADDRESS **3517 Leclere av.**

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.

45

2

