

DEC 20 1930

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

Do not use this space.

38710

1. PLACE OF DEATH

County Caldwell
Township
City Polo (No.)

Registration District No. 99
Primary Registration District No. 4061

File No.
Registered No. 17
St. Ward)

2. FULL NAME

Margaret J. Crowley

(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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) widow

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 1930

5a. If MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF J. H. Crowley

17. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19....., that I last saw h. alive on, 19....., and that death occurred, on the date stated above, at 6:30 P. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-4-1858

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy (Instantaneous)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 9

CONTRIBUTORY (SECONDARY) 7400
(duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wif
(b) General nature of industry, business, or establishment in which employed (or employer)

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

9. BIRTHPLACE (CITY OR TOWN) Iowa
(STATE OR COUNTRY)

DID AN OPERATION PRECEDE DEATH? no DATE OF

10. NAME OF FATHER Frank Paxton

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Truesfield Iowa DATE OF BURIAL 12/6/1930

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

20. UNDERTAKER Alsbaugh & Cowley ADDRESS Polo Mo

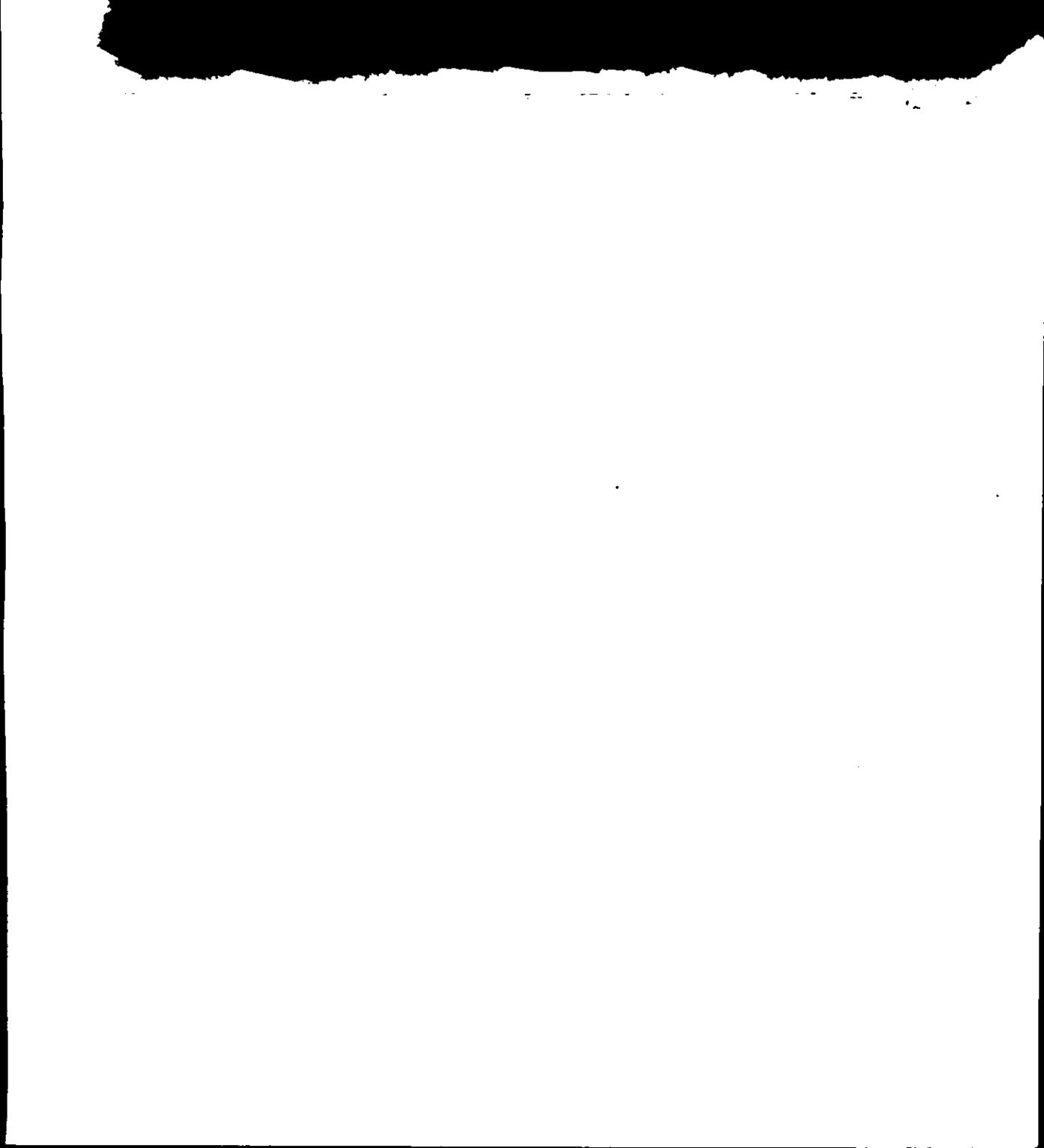
12. MAIDEN NAME OF MOTHER Mollisa St John

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

14. INFORMANT H. C. Crowley
(Address) Polo

15. FILED 19..... REGISTRAR

*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.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Calderwell

Registration District No. 99

File No.

Township

Primary Registration District No. 4061

Registered No. 17

City Osceola (No.) St. Ward)

2. FULL NAME

Margaret J. Crowley

(a) Resident. 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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

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.

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

Dec 30

D. L. Mount

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 1930

17. I HEREBY CERTIFY That I attended deceased from 19....., 19.....

that I last saw h. alive on 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.

, 19 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

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.

AW

SUPPLEMENTARY

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