

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

Do not use this space
16372
Hull
207
Registered No. _____
Ward _____

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 309
City Springfield, Mo (No. 932) Precinct _____ St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 932 20 Precinct 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>W. G. Crane</u>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 11 - 1855</u>			
7. AGE <u>80</u> YEARS	MONTHS <u>4</u>	DAYS <u>24</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>housewife</u>		
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Michigan</u>			
MOTHER	13. NAME <u>Unknown</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
	15. MAIDEN NAME <u>Unknown</u>		
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
	17. INFORMANT <u>Thos. Elmer Williams</u> (ADDRESS) <u>932 S. Cedar</u>		
18. BURIAL, CREMATION, OR REMOVAL FLAG <u>Interred</u> <u>8 5 1934</u>			
19. UNDERTAKER (ADDRESS) <u>Springfield, Mo</u>			
20. FILED <u>5-1934</u>			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 5, 1934

22. I HEREBY CERTIFY That I attended deceased from Nov 20, 1933 to May 5, 1934

I last saw him alive on 5-1-1934 Death is said to have occurred on the date stated above, at 11:45 p.m.

The principal cause of death and related causes of importance were as follows:

Valvular Heart Disease. Chronic
131
133

Date of onset _____

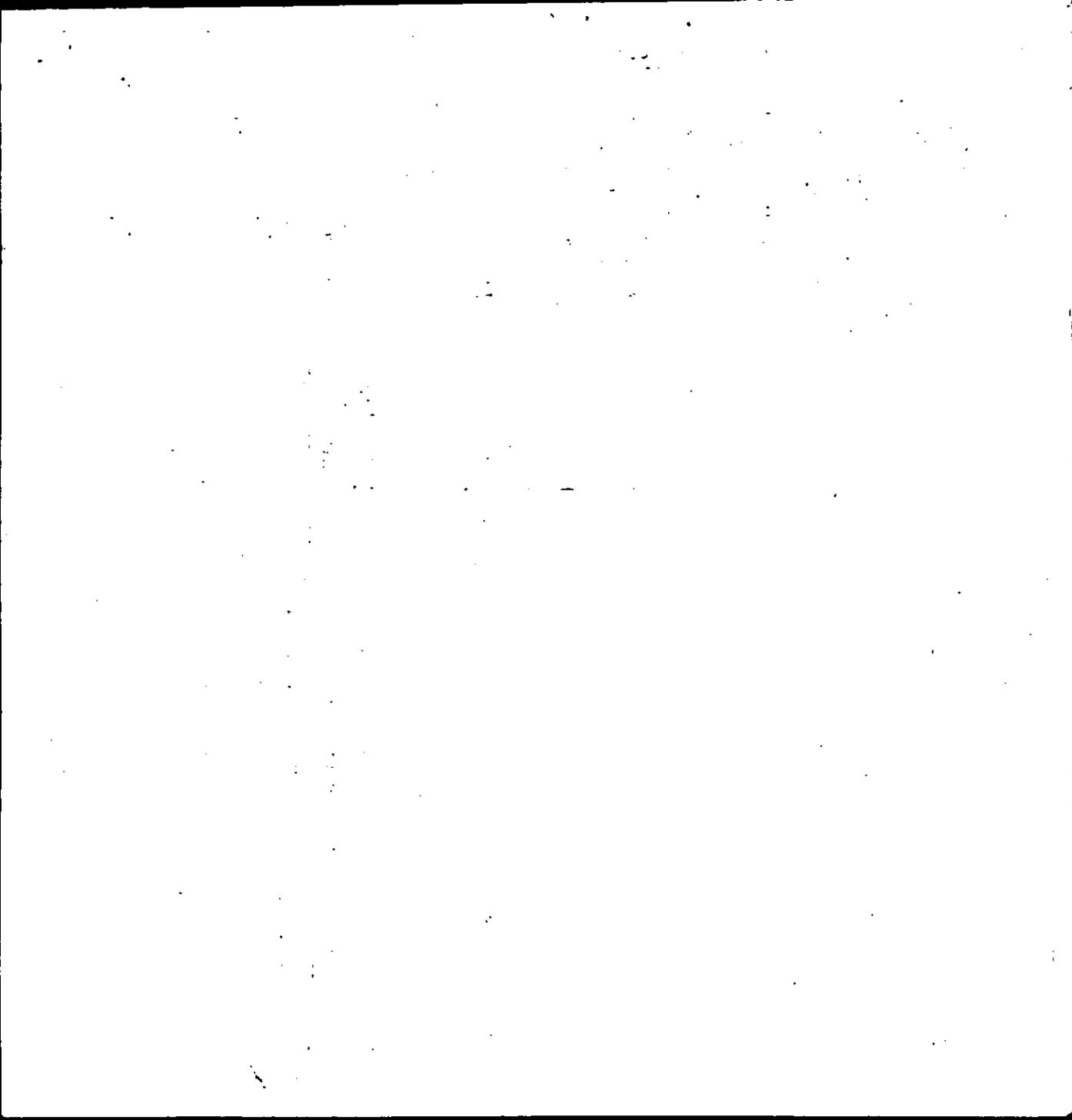
Other contributory causes of importance:
Disease of kidneys

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) H. Fullenacht, M. D.
(Address) Springfield, Mo



2 Green
Springfield

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McGaugh, M. D., X
Special Agent,
Jefferson City, Mo.
16372

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Mr. Helia Crane
Who died at _____ on May 5, 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex _____ Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 80 Months 4 Days 24

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____

Principal cause of death: Valvular Heart disease, Disease of Kidneys, Ch. Nephritis

Other contributory causes of importance _____
Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar [Signature]

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 318

Very truly yours,

Primary Reg. Dist. No. 2001

E. T. Mc-Gaugh
m. n.

Special Agent.

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