

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

Do not use this space.

JUN 16 1937

1. PLACE OF DEATH
 County Boone Registration District No. 75
 Township Pershe Primary Registration District No. 5114
 City (No. St. Ward)

2. FULL NAME Robert Crews
 (a) Residence, No. R 5 Columbia Mo. Ward. 1
 (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.

File No. 19424
 Registered No. _____
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 5 1876

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>60</u>	<u>10</u>	<u>23</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 28 1937

22. I HEREBY CERTIFY, That I attended deceased from May 24, 1937, to May 27, 1937
 I last saw him alive on May 28, 1937. Death is said to have occurred on the date stated above, at 11 P. m.
 The principal cause of death and related causes of importance were as follows:

Thrombosis of left Lung / possibly metastatic.

Other contributory causes of importance: X

Date of onset ?

12. BIRTHPLACE (CITY OR TOWN) Boone Co Mo
 (STATE OR COUNTRY)

FATHER

13. NAME Kelley Crews

14. BIRTHPLACE (CITY OR TOWN) Boone Co Mo
 (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Ollie Nicholson

16. BIRTHPLACE (CITY OR TOWN) Boone
 (STATE OR COUNTRY)

17. INFORMANT Josephine Crews
 (ADDRESS) 115 S 6th St

18. BURIAL, CREMATION, OR REMOVAL
 PLACE New Providence Co Mo DATE May 30 1937

19. UNDERTAKER R Ollivier
 (ADDRESS)

20. FILED 6-10-1937 Wm N. Gullett
 Registrar

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) Joseph T. Caffis, M. D.
 (Address) Columbia, Mo.

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.

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**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 Boone Registration District No. 7D
 Township Pershe Primary Registration District No. 2114
 City (No. _____) St. _____ Ward _____

File No. 19424
 Registered No. _____

2. FULL NAME Robert Crews

(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

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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.
60 10 23

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 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) _____

FATHER
 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS) _____

20. FILED 6-10-37 Mrs. H. Tullett Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 28, 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Tumor of left lung
parapharyngeal metastatic
primary malignant tumor
upper lobe of left lung

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

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

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) Joseph F. Caples, M. D.

(Address) Columbia, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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5-19424