

View 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.

OCT 19 1937

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

Do not use this space.

33155

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

1. PLACE OF DEATH *Mercy Hospital*
 County *Jackson* Registration District No. *399*
 Township *Kew* Primary Registration District No. *1002*
 City *Kansas City, Mo.* (No. *Mercy Hospital*)
 2. FULL NAME *Billie Rose Crouch*
 (a) Residence, No. *604 N. Sterling*, St. _____ Ward. *Sugar Creek*
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred _____ yrs. — mos. *16* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>November 15, 1935</i>		
7. AGE YEARS <i>1</i>	MONTHS <i>2nd</i>	DAYS <i>16</i>
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>None</i>	
	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) <i>Sugar Creek MO.</i>		
FATHER	13. NAME <i>Wallace Crouch</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Kansas City, MO.</i>	
MOTHER	15. MAIDEN NAME <i>Lillian Stuart</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Kansas City, MO.</i>	
17. INFORMANT (ADDRESS) <i>Wallace Crouch 604 N. Sterling, Sugar Creek</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Mt. Washington</i> DATE <i>Sept. 3, 1937</i>		
19. UNDERTAKER (ADDRESS) <i>Wamsley Guardian Funeral Home 711 W. Lex. Indep. Mo.</i>		
20. FILED <i>Sept 2, 1937 M. M. Crowe Registrar.</i>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 31, 1937*

22. I HEREBY CERTIFY, That I attended deceased from *Aug. 18, 1937, to Aug 31, 1937*
 I last saw her alive on *Aug. 31, 1937*. Death is said to have occurred on the date stated above, at *11:00 p.m.*
 The principal cause of death and related causes of importance were as follows:
Specific Peritonitis, general (Pneumococcus)
 Date of onset *Aug 4, 1937*

Other contributory causes of importance:
129
Confluent Bronchopneumonia
Fibrous pleurisy

Name of operation _____ Date of _____
 What test confirmed diagnosis? *Autopsy* Was there an autopsy? *yes*

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) *Dr. Sidney Pakula* M. D.
 (Address) *Professional Bldg.*
 By *Dr. David Moutz*
Mercy Hosp.

11.11.11

10.10.10