

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

Do not use this space.

14999

1. PLACE OF DEATH

County Monteair
Township _____
City Clarksburg (No. _____)

Registration District No. 1095
Primary Registration District No. 4334

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

2. FULL NAME

Nancy Jane Crawford
(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
(write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sam Crawford
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 23, 1854
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 5 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(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) Missouri
10. NAME OF FATHER John Bybee
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Laura Parks
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Missouri

14.

INFORMANT E. M. Crawford
(Address) Clarksburg Mo.

15.

FILED 4-17, 1931 J. G. Martin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-11-1931

17. I HEREBY CERTIFY, That I attended deceased from _____ 1931, to _____ 1931, that I last saw her alive on 4-11-1931, and that death occurred, on the date stated above, at 11:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
HA
1076 (duration) _____ yrs. mos. ds.

CONTRIBUTOR (SECONDARY)

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. B. Farison M. D.
4-12-1931 (Address) Clarksburg, Mo.

*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

Union Cemetery
Monteair Mo.
4-13-1931

20. UNDERTAKER

ADDRESS

Jessie E. Richards
Sister

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

MAY 27 1931

