

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.

PLACE OF DEATH

County Cole  
Township Marion  
or  
Village  
or  
City (NO. St. Ward)

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

Registration District No. 211 File No. 24, 5E  
Primary Registration District No. 5291 Registered No. 31296-20

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Anna Katherine Crick

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED single (Write the word)

DATE OF BIRTH. April 23, 1919  
(Month) (Day) (Year)

AGE 1 yrs. 5 mos. 25 ds. IF LESS than 1 day, hrs. or min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work not working  
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE  
(City or town, State or foreign country) McGirk mo

PARENTS  
NAME OF FATHER Henry Frederick Crick  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Monitauco mo  
MAIDEN NAME OF MOTHER Lidia Helen Schull  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Monitauco mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lidia Helen Crick  
(ADDRESS) McGirk mo

Filed 10/18/20 by J. E. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 17, 1920  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 10, 1920, to Oct 17, 1920, that I last saw h. alive on Oct 17, 1920, and that death occurred, on the date stated above, at 9 P.m.

The CAUSE OF DEATH\* was as follows:

Sho Colitis  
11/23  
10/4  
(Duration) yrs. mos. 8 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.  
(Signed) B. H. Dooly M. D.  
Oct 18, 1920 (Address) Centertown mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Salmon Runum Church DATE OF BURIAL 10/18/20

UNDERTAKER Jack Bowlin ADDRESS Centertown

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

**PLACE OF DEATH**

County \_\_\_\_\_ Township \_\_\_\_\_ or \_\_\_\_\_ File No. \_\_\_\_\_  
 Village \_\_\_\_\_ or \_\_\_\_\_ Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_  
 WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_ (If ride the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

OCCUPATION \_\_\_\_\_  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE \_\_\_\_\_  
 (City or town, State or foreign country)

NAME OF FATHER \_\_\_\_\_

BIRTHPLACE OF FATHER \_\_\_\_\_  
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER \_\_\_\_\_  
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_ 191 \_\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191 \_\_\_\_\_, to \_\_\_\_\_, 191 \_\_\_\_\_  
 that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191 \_\_\_\_\_  
 and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 The CAUSE OF DEATH\* was as follows:

Contributory (secondary) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 M. D. \_\_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) \_\_\_\_\_  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted if not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191 \_\_\_\_\_  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_