

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

Do not use this space.

30021

1. PLACE OF DEATH

County..... Registration District No. *31*
 Township *St Louis* Primary Registration District No. *132*
 City *St Louis* No. *1907 Fallon St* St. _____ Ward _____

File No. _____
 Registered No. *8904*
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. *21* 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 OR (OR) WIFE OF *Nora Craden*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 23-1863*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
63 4 21
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Night Watchman*
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *St Louis*
 (STATE OR COUNTRY) *Missouri*
 10. NAME OF FATHER *John B Craden*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St Louis*
 (STATE OR COUNTRY) *Missouri*
 12. MAIDEN NAME OF MOTHER *Nora Benson*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St Louis*
 (STATE OR COUNTRY) *Missouri*

14. INFORMANT *Nora Craden*
 (Address) *1907 Fallon St*

15. FILED *SEP 15 1926* *Marb Starckoff*
 REGISTERED

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 14 1926*
 17. I HEREBY CERTIFY, That I attended deceased from *June* _____, 1926, to *Sept 14* _____, 1926, that I last saw him alive on *Sept 14* _____, 1926, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
131
Central hemorrhage
Apoplexy (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY *chronic nephritis*
 (SECONDARY) (duration) *6* yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF BIRTH _____
 DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____
 WAS THERE AN AUTOPSY? *no*
 WHAT TEST CONFIRMED DIAGNOSIS? *microscopic*
 (Signed) *Orval H. Olsen*, M. D.
Sept 14, 1926 (Address) *3148 Olive St*

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary Cemetery* DATE OF BURIAL *9/16 1926*

20. UNDERTAKER *Arthur J Donnelly* ADDRESS *2039 Wash St*

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.

