

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

Do not use this space.

4995
13 17

1. PLACE OF DEATH

County Graham
Township Law
City St. Charles, Mo.

Registration District No. 399

Primary Registration District No. St. Joseph Hospital

File No. _____
Registered No. 1501 Ward _____

2. FULL NAME

Charles Craven

(a) Residence. No. 2932 Michigan St. 4 Ward.

(Usual place of abode) 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Etta Craven</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Apr-1-1856</u>		
7. AGE <u>73</u>	YEARS <u>10</u>	MONTHS <u>10</u>
	DAYS <u>10</u>	IF LESS than 1 day,hrs. ormin.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Foundry Manager</u> (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 Thos. Craven

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Bettie Austin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no Record

14. INFORMANT Etta Craven
(Address) 2932 Michigan Ave

15. FILED 12 19 30 M. M. Cronin REGISTRAR
Ans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 5:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carbon monoxide gas
(accidental) 118C
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 181
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH..... 31

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy
(Signed) Henry McKee, M. D.
11 19 30 (Address) Deputy Coroner

*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 Forest Hill DATE OF BURIAL Feb 13, 1930

20. UNDERTAKER Mrs C. L. Foster ADDRESS K.C. Mo.

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.

14
30

