REC'D APR 15 1939

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

10304
Do not use this space.

1. PLACE OF DEATH
(a) County Callaway 2 1 Registration District No. 102
(b) Township Jackson Primary Registration District No. 5150 Registered No. 14
(c) City ..... (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 623 Mary Elizebeth Craighead
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C. R. Craighead
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 10, 1874
7. AGE YEARS 64 MONTHS 5 DAYS 22 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as 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) Portland, Mo. 0 1

FATHER
13. NAME Benjamin T. Winn
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield, Ill. 0

MOTHER
15. MAIDEN NAME Martha Ann Hunter
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Portland, Mo.

17. INFORMANT (ADDRESS) C. R. Craighead Aux Vasse, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Aux Vasse DATE Mar. 4 1939
19. FUNERAL DIRECTOR (ADDRESS) Hughes Maupin Aux Vasse Mo.
20. FILED 3-4 1939 C. B. Nichols Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 2 1939

22. I HEREBY CERTIFY, That I attended deceased from March, 1936, to Mch 2, 1939
I last saw her alive on Mch 2 - 1130 Am 1939. Death is said to have occurred on the date stated above, at 11:30 Am.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Heart failure	

Other contributory causes of importance:

Infected Gall bladder

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

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? No
If so, specify .....
(Signed) S. F. Toulson, M. D.
105 (Address) Mexico Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import[illegible]

[illegible] THIS IS A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I, Hughes Manpin, Licensed Embalmer No. 2358

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Hughes Manpin

Licensed Embalmer No. 2358

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

10304
Do not use this space.

1. PLACE OF DEATH
(a) County Calloway Registration District No. 102
(b) Township Primary Registration District No. 5150 Registered No. 14
(c) City Jackson (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Elizabeth Craighead
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

Date of onset
Heart failure
Pericarditis
Myocarditis

Other contributory causes of importance:
Infected gall bladder
Stone
Cholecystitis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy?

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) G. F. Woalson, M. D.
(Address) Mexico Mo.

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MAY - 3 1939