

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27668  
Registrar's No. 2718

Registration District No. 200

1. PLACE OF DEATH: Adair  
(a) County Adair  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Greencastle Mo. R. F. D.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 40yr.  
In this community 40yr.  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Pernia Victoria S. Craig  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Milon Craig  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased April 8 1892  
(Month) (Day) (Year)

8. AGE: Years 49 Months 4 Days 20  
If less than one day hr. min.

9. Birthplace Sticklerville Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation home

11. Industry or business Calvin Smith

12. Name Calvin Smith

13. Birthplace Adair Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Leona Bailey

15. Birthplace Adair Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Milon Craig  
(b) Address Green Castle Mo. R?F.D.No.3

17. (a) Burial (b) Date thereof 8-22-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cheesman Cemt.  
18. (a) Signature of funeral director [Signature]  
(b) Address Kirksville Mo.  
19. (a) Aug 27/41 (b) Spencer L. Freeman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Adair  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Green Castle Mo. R.F.D. #3  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22  
year 1941 hour 1:00P.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 8-16-41  
\_\_\_\_\_, 1941, to 8-16, 1941;  
that I last saw her alive on 8-16-41, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of cervix  
Carcinoma of R. Breast

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy note done

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature H. J. Pitts (M. D. or other) M. D.  
Address Lincoln, Mo Date signed 8/26/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 9-41-1661

Date Filed SEP 16 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ .....

Laura Riley

Registered ~~Apprentice~~ No. 3907

working under my personal supervision.

Signed

Laura Riley

Licensed Embalmer No. 3907

P. O. Address Kirksville Mo.

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.)

If this body is not embalmed, fact should be so stated above.