DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 29 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29557

Registration District No. 831 Primary Registration District No. 6092 Registrar's No. 19

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

1. PLACE OF DEATH:
(a) County: Shelby
(b) City or town: Shelbyville—Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Black Creek Tree
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Shelby
(c) City or town: Shelbyville - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Ferdinand Claybourne Craigmyle
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Maude E. Craigmyle
6. (c) Age of husband or wife if alive: 63 years
7. Birth date of deceased: Feb. (Month) 18 (Day) 1873 (Year)

8. AGE: Years	Months	Days	If less than one day
68	5	2	hr. min.

9. Birthplace: Shelby Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business .....
FATHER 12. Name: Ferdinand C. Craigmyle
FATHER 13. Birthplace: Ky. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Sallie Messick Evans
MOTHER 15. Birthplace: Md. (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Maude Craigmyle
(b) Address: Shelbyville, Mo.
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof: July 22-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Dale Cemetery
18. (a) Signature of funeral director: E. P. Thompson
(b) Address: Shelbyville, Mo.
19. (a) July 22 (Date received local registrar) 41 (b) Pearl Gore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1941 hour 13 minute 30 P.M.
21. I hereby certify that I attended the deceased from May 2, 1941, to July 18, 1941; that I last saw him alive on July 18, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Nephritis - IV	4 months
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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? (Specify type of place)
While at work? (e) Means of injury .....
23. Signature: R. L. Caldwell (M.D. or other) M.D.
Address: Shelbyville, Mo. Date signed July 22

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED
District Health Officer No. 10
District File Number 8-41-1553
Date Filed AUG 20 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 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed E. P. Thompson

Licensed Embalmer No. 1632

P. O. Address Shelbyville

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

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

S. No. 2B
M—8-21-41
I X29288

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29557

Registration District No. 831 Primary Registration District No. 6092 Registrar's No.

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

Shelbina Mo

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Shelbyville Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ferdinand C. Craigmyle

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 18 1873
(Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis - Chronic

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

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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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature A. L. Caldwell (M. D. or other)
Address Date signed

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH

WARD CERTIFICATE OF DEATH

State File No.....

Registration District No..... Registrar's No.....

19. THE DECEDENT'S RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL.")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....day.....

year.....hour.....minute.....M.

21. I hereby certify that I attended the deceased from.....

.....19....., to.....19.....;

last saw living alive on.....19.....;

death occurred on the date and hour stated above.

cause of death.....

	Duration

(3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

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