

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43343

State File No. _____

FILED JAN 5 1944
Registration District No. 1944/9

Primary Registration District No. 1002

Registrar's No. 5395

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
General Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12-3-43-12-15-3
(Specify whether years, months or days)

In this community 50 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2303 Michigan
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN CRAIG

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4 1848
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

95 5 11 hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

{ 13. Birthplace Unknown
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) BURIAL (b) Date thereof 12/21/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn Cem.

18. (a) Signature of funeral director Arthur W. Halliday

(b) Address 1520 N. 5th St. KCK

19. (a) 12-20-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15
year 1943 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from December 3, 1943,
December 15, 1943
that I last saw him alive on December 15, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy
Duration _____

Due to Cerebral Sclerosis

Due to 87d

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? _____

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

23. Signature J. P. Brown (M. D. or other) _____

Address San. Exp. 72 600 E 22nd Date signed 12/21/43

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

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 *Nathan H. Hatcher*

Licensed Embalmer No. *2700*

P. O. Address *1520 N. 5th St.*

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.