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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 28 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1321

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 96

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2401 Prospect
(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 23 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 2401 Prospect
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joseph Edgar Craig
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hattie Bell Craig
6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Laborer
11. Industry or business Retired
FATHER
12. Name No Record
13. Birthplace (City, town, or county) No Record (State or foreign country)
MOTHER
14. Maiden name No Record
15. Birthplace (City, town, or county) No Record (State or foreign country)
16. (a) Informant Irvin C. Craig
(b) Address 1609 Bristol, K.C.Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Washington Cemetery
18. (a) Signature of funeral director Sheil Funeral Home
(b) Address 6606 Indep. Ave. K.C.Mo.
19. (a) Jan 9 1944 (Date received local registrar) F E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8 year 1944 hour 3 minute 05 A.M.
21. I hereby certify that I attended the deceased from Dec 31, 1943, to Jan 5, 1944; that I last saw him alive on Jan 7, 1944; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Myocarditis
Metastatic carcinoma
Due to Non Hemorrhagic
Chronic nephritis
Due to 46f

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations
Of autopsy Hypostatic hemorrhagic & carcinoma - Pulmonary

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 Richard C. Shuck (M. D. or other) DO
Address 1100 E 12 Warren Date signed 1-10-44

360 (Licensed Embalmer's Statement on Reverse Side)

PERMANENT 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.....

Licensed Embalmer No.....

P. O. Address.....

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.

No. 2B
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1821

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 96

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:
(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 (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 Joseph Edgar Cray
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 Unknown (Month) (Day) (Year)
8. AGE: Years about 76 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Iowa (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) T E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8 year 1944 hour 1 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

	Duration
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY