

Registration District No. **43**

Primary Registration District No. **3007**

Registrar's No. **360**

**1. PLACE OF DEATH:**

(a) County **Butler**  
(b) City or town **Poplar Bluff**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Grand & Lexington Sts. 3**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 mo.** (Specify whether years, months or days)  
In this community **2 mo.** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo.** (b) County **BUTLER 12**  
(c) City or town **rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Butler County**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Liza Jane Craig**

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

4. Sex **Female** 5. Color of race **White**  
6. (a) Single, widowed, married, divorced **W 2**  
6. (c) Age of husband or wife if alive **2** years  
7. Birth date of deceased **Oct. 2, 1861**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**85 0 25** hr. **10** min.

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

10. Usual occupation **Housekeeper**

11. Industry or business **none**

MOTHER FATHER { 12. Name **Dick Martin** /  
13. Birthplace **Logan Co., Ill.** (City, town, or county) (State or foreign country)  
14. Maiden name **WILKINSON Mathis**  
15. Birthplace **U. S. A.** (City, town, or county) (State or foreign country)

16. (a) Informant **J. P. Craig**  
(b) Address **Poplar Bluff, Mo.**  
17. (a) **Burial** (b) Date thereof **Oct. 29, '46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **KANSAS CEM.**  
18. (a) Signature of funeral director **N. S. Phelps**  
(b) Address **Poplar Bluff, Mo.**

19. (a) **11/12/46** (b) **Wm. H. Burton**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Oct.** day **27th**  
year **1946** hour **5** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **Sept. 10**  
**1946** to **Oct. 27, 46**;  
that I last saw her alive on **Oct. 24,** 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia** Duration **3 da.**  
Due to **Bed sore over Lumbar reg. 30 da.**

Due to **Accidental fall and fracture of left acetabulum** **2 mo.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

**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) **10**  
(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 **0**  
23. Signature **Wm. H. Burton** (M. D. or other) **0**  
Address **Poplar Bluff, Mo.** Date signed **10-28-46**

RECEIVED

District Health Office N

District File Number 1146-

Date Filed 11-21-46

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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

*N. T. Phelps*

Licensed Embalmer No. 3231

P. O. Address

*Caplan Building*

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.

Registration District No. 43

Primary Registration District No. 3007

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Caplar Bluff  
(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)

3. (a) PRINT FULL NAME

Liza J. Craig

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Oct 2 (Month) 1946 (Day) 1946 (Year)

8. AGE: Years 85 Months 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

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

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

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month Aug Year 1946 Hour 2 minute 7 M.

21. I hereby certify that I attended the deceased from 1946 to 1946 that I last saw him alive on Aug 20 and that death occurred on the date and hour stated above. Immediate cause of death

Due to Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident ✓  
(b) Date of occurrence August 20, 1946  
(c) Where did injury occur? at home on farm (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home on farm  
While at work? Yes (Specify type of place) loss of equilibrium (a) Means of injury  
23. Signature W. H. Barton (M. D. or other) M.D.  
Address Caplar Bluff, Mo Date signed 12-7-46

SUPPLEMENTARY

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

36201