

No. 2
-12-45
5-17-39
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35296**
Registrar's No. **107**

FILED NOV 5 1947

Registration District No. **278**

Primary Registration District No. **3054**

1. PLACE OF DEATH:

(a) County Pike

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

(c) Name of hospital or institution:
Pike Co. Hospital **0**
(If not in hospital or institution, write street number or location)

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

In this community Lifetime
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike **82**

(c) City or town Louisiana **2**
(If outside city or town limits, write "RURAL")

(d) Street No. 600 South Carolina **1**
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) **0**

If yes, name country _____

3. (a) PRINT CALLIE NEVADA CRAIG
FULL NAME

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month Oct. day 11
year 1947 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from Oct 9
to Oct 11, 1947 to Oct 11, 1947
that I last saw h. alive on Oct 11, 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife James Robert Craig

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

7. Birth date of deceased May 2 1858
(Month) (Day) (Year)

Immediate cause of death Myocardial Failure Duration: 3 days

Due to Acute left sided Heart Failure 2 days

Due to Pulmonary Edema Hypertension yrs

Other conditions Old age

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

89 5 9 hr. min.

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

9. Birthplace Lincoln Co. Missouri **0**
(City, town, or county) (State or foreign country)

10. Usual occupation Hswfe.

11. Industry or business _____

12. Name Philiander Logan **1**

13. Birthplace Shelby Co. Ky. **1**
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Virginia West **1**
(City, town, or county) (State or foreign country)

15. Birthplace Norfolk Va. **1**
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Harry Craig

(b) Address Nebo. Illinois

17. (a) Burial (b) Date thereof 10/12/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverview Cem.

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? _____

18. (a) Signature of funeral director Haley Mortuary

(b) Address Louisiana, Missouri

19. (a) 10/11/47 (b) Bernice Callier
(Date received local registrar) (Registrar's signature) **1911**

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

23. Signature Chas H Rowdell (M. D. number) MD

Address Louisiana, Mo. Date signed Oct 12 1947

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

RECEIVED
District Health Officer No. 10
District File Number 11-47-1215
Date Filed NOV - 4 1947

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 *George O. Hagner*
Licensed Embalmer No. *3773*
P. O. Address *Louisiana 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.