

FILED SEP 17 1948

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 260

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Callaway County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Hours
In this community Six years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway
(c) City or town Fulton
(If outside city or town limits, write "RURAL")
(d) Street No. 211 W 5th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME State Ira Craghead

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Gus Craghead 6. (c) Age of husband or wife if alive 4 years
7. Birth date of deceased: Nov 4 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>9</u>	<u>27</u>	hr. _____ min. _____

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

10. Usual occupation Attendant at State Hospital

11. Industry or business _____

12. Name James Madison Davis

13. Birthplace St Aubert (Now Mokane) Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Eleanor White
(City, town, or county) (State or foreign country)

15. Birthplace Louisville Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Craghead

(b) Address Fulton, Missouri

17. (a) Burial (b) Date thereof 9-2-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hillcrest

18. (a) Signature of funeral director Hallace Funeral Home
(b) Address 7 W 6th St. Fulton, Missouri

19. (a) 9-2-1948 (b) Joseph M. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31 year 1948 hour 10:00 minute _____ PM.

21. I hereby certify that I attended the deceased from August 25 1948, to August 31 1948;

that I last saw her alive on August 31, and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma

Due to Diabetes Mellitus 2 1/2 yrs.

Other conditions Acute uremia
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 61

Duration 12 hrs.

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 2

Signature D. A. ... (M.D. or other) 20

Address Fulton, Mo. Date signed 9/1/48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed SEP 15 1948

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..... 2724

P. O. Address..... Fulton, Miss

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.