

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26301**

FILED AUG 25 1951

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>5160</u>		Registrar's No. <u>223</u>			
1. PLACE OF DEATH a. COUNTY <u>Callaway</u> 0140				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Calwood Twp</u>		c. LENGTH OF STAY (in this place) <u>6 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u> 0143					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Two Mi. So. Calwood</u>				d. STREET ADDRESS (If rural, give location) <u>414a Market St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>		b. (Middle) <u>Clyde</u>		c. (Last) <u>Craghead</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 15 1951</u>			
5. SEX <u>Male</u> <input checked="" type="radio"/>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 3, 1860</u>			
9. AGE (In years) <u>91</u>		IF UNDER 1 YEAR (Months) <u>1</u>		IF UNDER 12 HRS. (Days) <u>12</u>		IF UNDER 24 HRS. (Hours) (Min.) _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>		11. BIRTHPLACE (State or foreign country) <u>South of Fulton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		
13a. FATHER'S NAME <u>Cal Craghead</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Ann Douglas</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Lucy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Walter Craghead, Fulton, Mo R.R # 1</u>			ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES <u>Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? <u>331X</u> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>1949</u> , to <u>8-15</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>8-15</u> , 19 <u>51</u> , and that death occurred at <u>9:54</u> a.m., from the causes and on the date stated above.									
23a. SIGNATURE <u>John J. Brown MD</u> (Degree or title)				23b. ADDRESS <u>Fulton</u>		23c. DATE SIGNED <u>8-15-51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug, 17, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rural E. Fulton, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Aug-15-1951</u>		REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u> <u>426</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home, Fulton Mo</u> ADDRESS _____					

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

File No. _____
DISTRICT HEALTH OFFICE No. 4
AUG 20 1951

RECEIVED

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Russell C. Maag

Licensed Embalmer No. 4809

P. O. Address Fulton, 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.