

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **1079**

FILED JAN 26 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **53-C**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 2321 N. Franklin	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print) SIDNEY F. McCRACKEN			4. DATE OF DEATH January 17 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 18 Feb. 1906		9. AGE (In years last birthday) 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Technicial		10b. KIND OF BUSINESS OR INDUSTRY Own Laboratory		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
				12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Beverly McCracken		13b. MOTHER'S MAIDEN NAME Nancy Jane Hembree		14. NAME OF HUSBAND OR WIFE Lois Carter McCracken	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-03-3837		17. INFORMANT'S SIGNATURE OR NAME Lois McCracken ADDRESS Springfield, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH unknown
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchiogenic carcinoma		DUE TO (b) _____			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary embolism					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

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)		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 **October**, 19**51**, to **January**, 19**53**, that I last saw the deceased alive on **Jan. 17**, 19**53**, and that death occurred at **12:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. Richard Webb Jr., M.D.			23b. ADDRESS Springfield, Missouri		23c. DATE SIGNED 1/20/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/20/53	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Mo.

DATE REC'D BY LOCAL REG. 1-20-53		REGISTRAR'S SIGNATURE Edith Williamson Registrar		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. KLINGNER & CO. Springfield, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

396
C

100X

100X

100X

100X

100X

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 Oglestone Jr

Licensed Embalmer No. 4176

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.