

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11383

State File No.

No. 300
10. 48

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>116</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				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 the township) OR TOWN <u>Fulton Mo.</u>		c. LENGTH OF STAY (In this place) <u>17 Days</u>		c. CITY OR TOWN <u>Fulton</u>		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #1, Fulton Mo.</u>				e. STREET ADDRESS (If rural, give location) <u>801 Grand Street, #143</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SUSIE ELIZABETH</u> b. (Middle) <u>CRAIGHEAD</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>May 6, 1954</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>June 12, 1874</u>	
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>23</u>		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Callaway County, Mo.</u>		12. CITIZENRY OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Hamilton</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Davis</u>		14. NAME OF HUSBAND OR WIFE <u>D. K.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>D. K.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Records of State Hospital #1, Fulton, Mo.</u> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho-Pneumonia</u> ANTECEDENT CAUSES DUE TO (b) <u>Apoplexy</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> 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>2 Days</u> <u>2 Days</u>
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		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 <u>April 19, 1954</u> , to <u>May 5, 1954</u> , that I last saw the deceased alive on <u>May 5, 1954</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. S. Karaich, M.D. by J. S. Tucker</u>			23b. ADDRESS <u>State Hospital #1, Fulton, Mo.</u>		23c. DATE SIGNED <u>5-6-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 8, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		24d. LOCATION (City, town, or county) (State) <u>Fulton Mo.</u>	
DATE REC'D BY LOCAL REG. <u>May 6, 1954</u>		REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home</u>		ADDRESS <u>Fulton, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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, Student Embalmer No..... working under my personal supervision:.

Student.....
Signature of Student Embalmer

Signed *William C. Trebb*.....

Licensed Embalmer No. *487*.....

P. O. Address *Kulston*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.