

XC 2419469 FILED MAR 7 1955
REG. 6705 SL 230

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6080**
Registrar's No. **1631**

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____ b. CITY OR TOWN <u>St. Louis, Mo.</u> c. LENGTH OF STAY (in this place) <u>11 HOURS</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VETERANS ADMINISTRATION HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____ c. CITY OR TOWN <u>ST. LOUIS</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> STREET ADDRESS (If rural, give location) <u>249 3751 SOUTH JEFFERSON AVENUE</u>			
3. NAME OF DECEASED a. (First) <u>ARTHUR</u> b. (Middle) _____ c. (Last) <u>CRAIG</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-18-55</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>9-24-76</u>		9. AGE (In years last birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>traveling salesman</u>		11. KIND OF BUSINESS OR INDUSTRY <u>Manufacturer of Hardware Items</u>	
12. BIRTHPLACE (City and State or Foreign Country) <u>HIGHGATE, MISSOURI</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>WILLIAM L. CRAIG</u>		13b. MOTHER'S MAIDEN NAME <u>DORA FANN</u>	
14. NAME OF HUSBAND OR WIFE <u>LETTY CRAIG</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give year or dates of service) <u>YES SPAW</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>VA HOSPITAL RECORDS, ST. LOUIS, MO.</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PULMONARY EDEMA</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 Mins</u> ANTECEDENT CAUSES DUE TO (b) <u>CONGESTIVE FAILURE</u> DUE TO (c) <u>BLOOD TRANSFUSIONS</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>BLEEDING DUODENAL ULCER</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>5410</u>		22. I hereby certify that I attended the deceased from <u>2-18</u> , 19 <u>55</u> , to <u>2-18</u> , 19 <u>55</u> , that I last saw the deceased <u>at home</u> and that death occurred at <u>9:30 pm.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (In ink or title) <u>J. V. Lamb M.D.</u>				23b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>		23c. DATE SIGNED <u>2-18-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>FEB. 21 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>JEFFERSON BARRACKS</u>	
DATE REC'D BY LOCAL REG. <u>FEB 21 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Marrio</u>			

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

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.....
Samuel Hill

Licensed Embalmer No. *434*

P. O. Address *2906 E*

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.