

FILED APR 15 1957

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10109**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2825**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		a. STATE Missouri	
c. LENGTH OF STAY (in this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4183 W. Belle Place		c. CITY OR TOWN St. Louis	
e. STREET ADDRESS 4183 W. Belle Place		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED a. (First) A.		b. (Middle) WILLARD		c. (Last) CRADDOCK		4. DATE OF DEATH (Month) (Day) (Year) Mar. 19, 1957	
5. SEX Male 2		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /		8. DATE OF BIRTH Jan. 2, 1872	
9. AGE (In years last birthday) 85		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (City and State or Foreign Country) Marshall, Missouri 0	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Edwin Craddock		13b. MOTHER'S MAIDEN NAME Ophelia Johnson		14. NAME OF HUSBAND OR WIFE Livy Craddock	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Livy Craddock		ADDRESS 4183 W. Belle Pl.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Prostate		INTERVAL BETWEEN ONSET AND DEATH 3 years	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES 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.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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 May 10, 1956, to March 19, 1957, that I last saw the deceased alive on March 16, 1957, and that death occurred at 4:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Merle B. Jernford M.D.		23b. ADDRESS 918th N. Taylor		23c. DATE SIGNED 3-21-57	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/23/57		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
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DATE REC'D BY LOCAL REG. MAR 22 57		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates		ADDRESS 4107 Finney	
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.