Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000829
STATE FILE NUMBER

FILED JAN 21 1959 Registration District No. 114 Primary Registration District No. 4486 Registrar's No. 4

1. PLACE OF DEATH
a. COUNTY FRANKLIN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SULLIVAN — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WATSON ROAD — Length of stay in 1b 1½ YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY FRANKLIN
c. CITY OR TOWN SULLIVAN — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) WATSON ROAD — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First BESSIE Middle Last CRAIG
4. DATE OF DEATH Month JAN. Day 12 Year 1959
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH MARCH 11, 1900
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR Months 10 Days 1 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) FULTON, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME ? POTTS
13b. MOTHER'S MAIDEN NAME ELIZABETH
14. NAME OF HUSBAND OR WIFE JOSEPH P. CRAIG
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT JOSEPH CRAIG Address SULLIVAN, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VIRUS Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 WEEK.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Diabetes Mellitus — Cardiac Decompensation — Obesity
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 1958, to Jan 12, 1959 and last saw her/him alive on Jan 11, 1959
Death occurred at 10:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald K. Scott (Degree or title) DO
22b. ADDRESS Sullivan, Mo
22c. DATE SIGNED 1/14/59.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE JAN. 15, 1959
23c. NAME OF CEMETERY OR CREMATORY CORINTH CHURCH. CEM.
23d. LOCATION (City, town, or county) (State) FOLEY MO.

24. FUNERAL DIRECTOR H. Walton ADDRESS Sullivan, Mo
25. DATE RECD. BY LOCAL REG. Jan. 14-1959
26. REGISTRAR'S SIGNATURE Thomas G. Dempsey

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JAN 22 1959

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 J. A. Humphrey

Licensed Embalmer No. 4772

P. O. Address Lucedale, Miss.

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.