

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022108
STATE FILE NUMBER

S. 300
v. 1-57

FILED JUN 17 1959 Registration District No. 167 Primary Registration District No. 3040 Registrar's No. 153

1. PLACE OF DEATH a. COUNTY <u>Lumpkin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Lumpkin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Nazareth 829.</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>822 Cherry</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESS LOUIS CRAIN</u>			4. DATE OF DEATH Month Day Year <u>6-9-1959</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1883</u>
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Druggist</u>	11. BIRTHPLACE (City and state or country) <u>Davis Co Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Isaac CRAIN</u>	
13b. MOTHER'S MAIDEN NAME <u>Mattie Lyford</u>		14. NAME OF HUSBAND OR WIFE <u>Emmie Bradford CRAIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>500-34-7108</u>	
17. INFORMANT Address <u>Mrs. Ronald Mahaly Galt MO</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia.</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>H2O1</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 <u>May 30-59</u> to <u>6-9-59</u> and last saw him alive on <u>6-9-59</u> Death occurred at <u>10:35 a m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph F. Galt M.D.</u>		22b. ADDRESS <u>Chillicothe Mo</u>	
22c. DATE SIGNED <u>6-10-59</u>		23a. BURIAL CREMATION, FUNERAL (Specify)	
23b. DATE <u>6-11-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Galt Cem.</u>	
23d. LOCATION (City, town, or county) <u>Galt</u>		23e. STATE <u>MO</u>	
24. FUNERAL DIRECTOR ADDRESS <u>PK Payne Son Galt Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6/10/59</u>	
26. REGISTRAR'S SIGNATURE <u>Frances B Kroll</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *PK Payne Jr*

Licensed Embalmer No. *3400*

P. O. Address *Salt*

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.