

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035405

FILED VS OCT 27 1959 47

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 268 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Callaway	Length of stay in 1b 12yrs.	a. STATE Mo.	b. COUNTY Callaway
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		c. CITY OR TOWN Fulton	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Callaway Memorial Hosp.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 836 Grand	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Mark	Middle Alfred	Last Craighead	4. DATE OF DEATH	Month Oct.	Day 21	Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-22-82	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during 10 years of work, if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Hams Prairie, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Mark Anthony Craighead	13b. MOTHER'S MAIDEN NAME Barbara Ann Debo	14. NAME OF HUSBAND OR WIFE Rosie
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Rosie Craighead, Fulton, Mo	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage	DUE TO (b) Hypertensive arteriosclerotic C.V.R.	DUE TO (c) with 2 previous strokes	INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Month, Day, Year
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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
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21. I attended the deceased from 24 Sept 59 to 21 Oct 59 and last saw him alive on 21 Oct 59
Death occurred at 9:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>E. R. Bish (M.D.)</i>	22b. ADDRESS <i>Fulton Mo</i>	22c. DATE SIGNED <i>23 Oct 59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 24 - 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Callaway Memorial Gardens</i>	23d. LOCATION (City, town, or county) <i>Fulton</i>	(State) <i>Mo</i>
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24. FUNERAL DIRECTOR <i>Hallow Funeral Home, Fulton, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>Oct. 23 - 1959</i>	26. REGISTRAR'S SIGNATURE <i>Maretha Lawrence</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 8 2 100 SA

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

A.R. Masure

Licensed Embalmer No. 4996

P. O. Address Fulton, Mo

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.