

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-007072

FILED VS MAR 14 1960

STATE FILE NUMBER

Registration District No. 283 Primary Registration District No. 5635 Registrar's No. 191

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt Vernon</u>		Length of stay in lb <u>32 years</u>	c. CITY OR TOWN <u>Mt Vernon</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hedges Nursing Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt 2 Mt Vernon</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>May</u> Last <u>Craig</u>			4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1960</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state of country) <u>Wrightstown, Wisconsin</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Louis Burnett</u>		13b. MOTHER'S MAIDEN NAME <u>Celestia Morrison</u>		14. NAME OF HUSBAND OR WIFE <u>Edward F. Craig</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>none</u>	17. INFORMANT <u>Mr William Hagen</u> Address <u>Rt 2 Mt Vernon, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial Failure</u>		<u>1 da</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Obstructive jaundice (Stones)</u>	<u>1 mo.</u>
	DUE TO (c) <u>Diabetes Mellitus</u>	<u>20 ynt.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>Senility</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <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>Jan 1940</u> to <u>3/3/60</u> and last saw her <u>alive</u> on <u>3/3/60</u> Death occurred at <u>4 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Benneth Glover MD</u> (Degree or title)	22b. ADDRESS <u>Mt Vernon, Mo</u>	22c. DATE SIGNED <u>3/5/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Mar-5-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>
23d. LOCATION (City, town, or county) <u>Mt Vernon, Mo.</u>	24. FUNERAL DIRECTOR <u>Max Fossitt</u> ADDRESS <u>Mt Vernon, Mo.</u>	25. DATE REC'D. BY LOCAL REG. <u>3-5-60</u>
26. REGISTRAR'S SIGNATURE <u>Max Fossitt</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by By Me _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max L. Fossett

Licensed Embalmer No. 425

P. O. Address Murkwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.