

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-027965**

FILED VS AUG 9 1960

STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 94

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmondburg</u>		Length of stay in lb <u>9 days</u>	c. CITY OR TOWN <u>Lawson</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSITUATION <u>Ray ss. Memorial Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7 miles E. of Lawson</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ELWOOD</u> Middle <u>OTTO</u> Last <u>CRAVEN</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</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>June-9-1901</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine Maintenance</u>		11. BIRTHPLACE (City and state or country) <u>Ray Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>Mo</u>

13a. FATHER'S NAME <u>William Craven</u>		13b. MOTHER'S MAIDEN NAME <u>Mahala Ray</u>		14. NAME OF HUSBAND OR WIFE <u>Addie Craven</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>495-24-4212</u>		17. INFORMANT <u>Mrs Addie Craven - Lawson mother</u> Address <u>  </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>Carcinomatosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>
DUE TO (b) <u>Carcinoma of lung</u>			
DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>  </u>			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

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.) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>		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.) <u>  </u>		20f. CITY, TOWN, OR LOCATION <u>  </u>	COUNTY <u>  </u> STATE <u>  </u>

21. I attended the deceased from 6-13-60 to death and last saw him alive on 7-29-60  
Death occurred at 7:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>D. G. Cozier MD</u>		22b. ADDRESS <u>Richmond, Mo.</u>		22c. DATE SIGNED <u>7-30-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City, town, or county) <u>Ray Co</u>	(State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>Norman Funeral Home - Lawson Mo</u> ADDRESS <u>  </u>		25. DATE RECD BY LOCAL REG. <u>8-2-1960</u>	26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>	

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 by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lindsey Janna

Licensed Embalmer No. 4589  
Essex Springs  
P. O. Address

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