

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043090

FILED VS DEC 6 1960

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 142

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana, Mo.</u>	Length of stay in 1b <u>1da.</u>	c. CITY OR TOWN <u>*****</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>Pike Co. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>*****</u>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Craig</u> Last <u>Stuart</u>	4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1960</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-28-1888</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	11. BIRTHPLACE (City and state or country) <u>Pike Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>W. C. Craig</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Smith</u>	14. NAME OF HUSBAND OR WIFE <u>*****</u>
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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) <u>No.</u> <u>*****</u>	16. SOCIAL SECURITY NO. <u>499-01-9894A</u>	17. INFORMANT Address <u>Mrs. Marlin Orf, Bowling Green, Mo.</u>
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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) <u>Medullary Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombotic encephalomalacia</u> <u>18 months</u> DUE TO (c) <u>arteriosclerosis</u> <u>unknown</u>		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 checked="" 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 <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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u> <u>  </u> <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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>Nov 24, 1960</u> to <u>Nov 25/60</u> and last saw her alive on <u>Nov 25, 1960</u> Death occurred at <u>2:01</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>David L. Bilyeu D.O.</u>	22b. ADDRESS <u>218 N 5th St. Louisiana, Mo</u>	22c. DATE SIGNED <u>11-26-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-27-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kilby</u>	23d. LOCATION (City, town, or county) (State) <u>Pike Co. Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Harold Kirks, Bowling Green, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 29-60</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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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 Harold Kirk

Licensed Embalmer No. 4591

P. O. Address Bowling

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.