

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048330

12467

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

FILED JAN 10 1963

VS 300
Rev. 4/59

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28/207

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED
1/23/63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

Columbus, Kentucky Thistlewood Mounds, Ill.

ITEM NO. SHOULD READ
23c, d

Columbus, Kentucky Thistlewood Mounds, Ill.

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Ill.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Alexander	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Cairo	
Length of stay in 1b _____		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 28 Edgewood	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CRESSIE CRAIG FLOWERS			4. DATE OF DEATH Month Day Year Dec. 26, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-26-88
9. AGE (last birthday) 74		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Columbus, Kentucky U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Wm. W. Craig	
13b. MOTHER'S MAIDEN NAME Lilla Marco		14. NAME OF HUSBAND OR WIFE widowed	
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. Mae F. Turner, University City		Address Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cancer of Breast DUE TO (c) 170X			INTERVAL BETWEEN ONSET AND DEATH
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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.		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 Dec. 23, 1962 to Dec. 26, 1962 and last saw her alive on Dec. 26, 1962		Death occurred at 9:45 PM on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Leroy L. Fink M.D.		22b. ADDRESS 634 W. Grand Ave.	
22c. DATE SIGNED 12-27-62		23a. BURIAL, CREMATION REMOVAL (Specify) Burial	
23b. DATE 12-29-62		23c. NAME OF CEMETERY OR CREMATORY Columbus Thistlewood Mounds - Illinois	
23d. LOCATION (City, town, or county) (State) Columbus, Kentucky		24. FUNERAL DIRECTOR ADDRESS Joseph Berbling, Cairo, Ill.	
25. DATE RECD. BY LOCAL REG. DEC 27 1962		REGISTRAR'S SIGNATURE Loan Smith, M.D.	

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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Hassley III

Licensed Embalmer No. 5039

P. O. Address Co. St. Louis, 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.

1. ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 08-11-2010 BY 60322/UCBAW/STP/STP