

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031359

042

1000

1005

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED AUG 26 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in 1b Most of Life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION THE COUNTRY HOUSE		d. STREET ADDRESS (If outside, give location) 2217 Marion Street	
5620 S. 22nd Street		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CRAIG			4. DATE OF DEATH Month Day Year August 18 1963		
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 Dec. 2, 1873	9. AGE (last birthday) 89	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kidder, Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Amos Craig		13b. MOTHER'S MAIDEN NAME Martha Hamlet	
14. NAME OF HUSBAND OR WIFE Mrs. Lulie J. Craig		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Wife		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		19. INTERVAL BETWEEN ONSET AND DEATH sudden	

IMMEDIATE CAUSE (a) Coronary occlusion		DUE TO (b) Arteriosclerotic Heart Disease		DUE TO (c) _____	
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			

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.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **July 1 1963** to **August 18 63** and last saw ^{her} him alive on **Aug. 18 1963**
Death occurred at **11.05 A.m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Orville W. Craig M.D.</i>	22b. ADDRESS 620 Francis Street St Joseph	22c. DATE SIGNED Mo 8-21-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 20, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Missouri	(State)
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24. FUNERAL DIRECTOR Meierhoffer-Fleeman Funeral Home, Inc.	25. DATE RECD. BY LOCAL REG. Aug 23, 1963	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>
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DO NOT WRITE ON THIS STUB	AMENDED	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	SHOULD READ	BY AFFIDAVIT OF
VS 300 Rev. 4/59							
1 <i>5117</i>							
2 <i>5117</i>							
3 <i>2</i>							
4 <i>0</i>							
5 <i>1</i>							
6							
7 <i>0</i>							
8 <i>0</i>							
9 <i>4200</i>							
10							
11							
12 <i>90-0</i>							
13 <i>1-0</i>							

USE BLACK INK OR TYPEWRITER RIBBON

BY MEDICAL CERTIFICATION
O.W. Craig, M.D.

Permit issued 8-19-63

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 *Bill J. Cherry*

Licensed Embalmer No. 4679

P. O. Address St. Joseph, 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.