

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034928

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 313

STATE FILE NUMBER

FILED SEP 30 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in lb year	c. CITY OR TOWN Greentop Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Stickler Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route # 3 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOHN NELSON CRAGG			4. DATE OF DEATH Month Day Year September 24 1963
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> Never Married Married	8. DATE OF BIRTH 9/5/73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (last birthday) 90 IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) Lincolnshire, England,		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME Nelson Cragg		13b. MOTHER'S MAIDEN NAME Edna Richardson	
14. NAME OF HUSBAND OR WIFE Sarah Newcum, Kirksville, Mo.		17. INFORMANT Address	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of stomach Emphysema 5271 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis 4500 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 mon. 2 yrs. 10 yrs.
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. 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 Nov. 29, 1962 to Sept. 24, 1963 and last saw him alive on Sept. 24, 1963		Death occurred at 12:40 a m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Ro Stickler M.D.		22b. ADDRESS 107 E. Harrison, Kirksville, Mo.	22c. DATE SIGNED 9/24/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/25/63	23c. NAME OF CEMETERY OR CREMATORY Ft. Madison	23d. LOCATION (City, town, or county) (State) Kirksville, Adair, Mo.
24. FUNERAL DIRECTOR ADDRESS Foster Memorial Home, Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 24, 1963	26. REGISTRAR'S SIGNATURE Maria W. Ratliff

OCT 1 1963

R. O. STICKLER, M.D.

No permit issued

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 *Nova E. Foster*
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, 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.