

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039849
STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5796

FILED NOV 7 1963

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>2 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Roanoke N. Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WORTH</u> c. CITY OR TOWN <u>GRANT CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>LEURA Pendleton CRAVEN</u>			4. DATE OF DEATH Month Day Year <u>OCT 26 1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-1876</u>	9. AGE (last birthday) <u>87</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <u>WORTH Co. MO.</u>	
13a. FATHER'S NAME <u>William Pendleton</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH WARD.</u>		14. NAME OF HUSBAND OR WIFE <u>SHANNON CRAVEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Don B. Hibbs 10 West. 43 St. No. K.C. 16 Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>Viral gastroenteritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>a few hrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>art. scl heart dis.</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
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19. WAS AUTOPSY PERFORMED? YES <input 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 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 10-26-63 **to** 10-26-63 **and last saw her** alive on 10/26/63
 Death occurred at _____ **on** the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>2730 S. Mall K.C. 19 Mo</u>	22c. DATE SIGNED <u>10/26/63</u>
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23a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct 26-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grant City Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Grant-City Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Andrews. Funeral Home</u>	25. DATE RECD. BY LOCAL REG. <u>10-26-63</u>	26. REGISTRAR'S SIGNATURE <u>Beasie Smith</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

DATE AMENDED	AMENDED
1	
2	1139-
3	
4	1
5	2
6	
7	0
8	0
9	5711
10	
11	
12	86-0
13	

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 John Andrews, Student Embalmer No. 4211
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Andrews
Licensed Embalmer No. 4211

P. O. Address Grant City 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.

ALL 27557

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