

Dr. Hanss  
**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

63-043482

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 122 Primary Registration District No. 2000 Registrar's No. 1630

STATE FILE NUMBER

FILED DEC 2 1963

VS 300  
 Rev. 4/59  
 10397  
 20397  
 3  
 4 0  
 5 1  
 6  
 7 1  
 8 2  
 9 4/201  
 10  
 11  
 12 1-0  
 13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GREENE</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>                   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>   |   | Length of stay in 1b <b>22 YRS.</b>   | c. CITY OR TOWN <b>SPRINGFIELD</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BURGE HOSP.</b>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>1452 E. STANFORD</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>KENNETH A. CRAIG</b>  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>NOV. 20 1963</b>  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-6-1899</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALES REPRESENTATIVE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD SUPPLIES</b>   | 11. BIRTHPLACE (City and state or country)<br><b>MEADVILLE, PA.</b>  |
| 13a. FATHER'S NAME<br><b>WILLIAM CRAIG</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>THERESA HOGUE</b>   | 14. NAME OF HUSBAND OR WIFE<br><b>THELMA CRAIG</b>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br>[ ]  | 17. INFORMANT Address<br><b>THELMA CRAIG SPRINGFIELD, MO.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Pulmonary emphysema</b>  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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: <b>Greene</b> STATE  |
| 21. I attended the deceased from <b>1956</b> to <b>Nov. 20, 1963</b> and last saw him alive on <b>Nov. 20, 1963</b><br>Death occurred at <b>6:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Armand W. Hanss M.D.</b>  |   | 22b. ADDRESS<br><b>600 S. Glenstone Springfield, Missouri</b>   | 22c. DATE SIGNED   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>11-23-63</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAZELWOOD CEMETERY</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>SPRINGFIELD, MISSOURI</b>  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>11-27-63</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Dennis Medley</b>  |

USE BLACK INK OR TYPEWRITER RIBBON

9-2117 1-17-63

OCT 19 1966

JAN 13 1964

11-22-63

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 Lucian L. Bradley

Licensed Embalmer No. 4815

P. O. Address Springfield, 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.