N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Pettis

Township ..... or Village ..... or City Sedalia (NO. ..... St.; ..... Ward)

Waters

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 668 File No. 16892

Primary Registration District No. 3032 Registered No. 132

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Craddoc

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Black

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: April 15 (Month) (Day) 1891 (Year)

AGE: 23 yrs. 1 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): R R

BIRTHPLACE (City or town, State or foreign country): Sedalia

PARENTS
NAME OF FATHER: George Craddoc
BIRTHPLACE OF FATHER (City or town, State or foreign country): Boonville Mo
MAIDEN NAME OF MOTHER: Fannie Newlan
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Arrock Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Craddock
(ADDRESS) Sedalia Mo

Filed May 2, 1914 H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May 2 (Month) (Day) 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 29, 1914, to May 1, 1914, that I last saw him alive on Apr 29, 1914, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis
23 A
(Duration) 28 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....
8 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. F. Waters M. D.
May 2 1914 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

PLACE OF BURIAL OR REMOVAL: Sedalia Mo. Col. cemetery
DATE OF BURIAL: May 3 1914
UNDERTAKER: McLaughlin Bros.
ADDRESS: Sedalia Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City .....(NO. .... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191.....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory.....
(SECONDARY)
.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS