WRITE PLAINLY, WITH UNFADING [illegible] THIS IS A PERMANENT RECORD

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 Newton

Township Granby
or
Village ~~Granby Mo R F D~~
or
City _____ (NO. _____ St.; _____ Ward)

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

Registration District No. 614
Primary Registration District No. 5846

File No. 35842
Registered No. 38

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

**FULL NAME** Geo W. Craton

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: male
COLOR OR RACE: White
~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Married

DATE OF BIRTH: Oct (Month) 15 (Day), 1857 (Year)

AGE: 59 yrs. 11 mos. 17 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Corning, Iowa

PARENTS
NAME OF FATHER: Ezekiel Craton
BIRTHPLACE OF FATHER (City or town, State or foreign country): Iowa
MAIDEN NAME OF MOTHER: Sarah Keethler
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Iowa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wyanda H. Tilton
(ADDRESS) Granby Mo R.F.D.

Filed 11-10, 1917. S K Wilbur
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Oct (Month) 2 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1, 1917, to Oct 2nd, 1917, that I last saw him alive on Oct 1st, 1917, near midnight and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Aneurysm of Abdominal Aorta following Gastric ulcer with erosions

117A (Duration) 81 yrs. 4 mos. ___ ds.

Contributory (SECONDARY) 91
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J B Hancock M. D.
10-3, 1917 (Address) Newtonia 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 30 yrs. ___ mos. ___ ds. In the State Ms ___ mos. ___ ds.
Where was disease contracted if not at place of death? at place of death
Former or usual residence same place

PLACE OF BURIAL OR REMOVAL: IOO F Cemetery
DATE OF BURIAL: Oct 4, 1917
UNDERTAKER: Paul Stader
ADDRESS: Neosho Mo

PLACE OF DEATH

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE 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**.....

## PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (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

..... (Month) ..... (Day), 191..... (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 |

NO.

LAINLY ... READING ... THIS IS A ... RMANENT RECORD

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.