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

Do not use this space.

32161

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9550

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME Edwin Craden

(a) Residence. No. 2423 A Fallon St. 21 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Della Craden

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 28 - 1890

7. AGE: Years 36 | Months 10 | Days 26. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis

PARENTS
10. NAME OF FATHER: John Craden
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St. Louis
12. MAIDEN NAME OF MOTHER: Nora Benson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St. Louis

14. INFORMANT: Hospital Informant
(Address): City Hospital

15. FILED ....., 19..... Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 24 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927, to Oct 24, 1927, that I last saw him alive on Oct 24, 1927, and that death occurred, on the date stated above, at 10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic interstitial nephritis
131

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 129a

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Edmund R. Sheridan, M. D

10/25, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary
DATE OF BURIAL: 10-27 1927

20. UNDERTAKER: Arthur J Donnelly
ADDRESS: 2039 Wash St

WRITE PLAINLY, WITH UNFADING INK---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.

Craden