

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

Do not use this space.

34708

1. PLACE OF DEATH

County..... Registration District No. **791** File No.....
 Township..... Primary Registration District No. **1003** Registered No. **9824**
 City *St. Louis, Mo.* (No. *Mo. Baptist Hosp.*) (Ward)

2. FULL NAME

(a) Residence, No. *Jackson, Mo.* (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>July 28, 1879</i>		
7. AGE YEARS <i>48</i>	MONTHS <i>3</i>	DAYS <i>4</i>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>News Dealer</i> (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) <i>Jackson - Mo.</i>		
10. NAME OF FATHER <i>John Craft</i>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) <i>Piquin, Ohio</i>		
12. MAIDEN NAME OF MOTHER <i>Mary Hostenbacher</i>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) <i>Salina, Ill.</i>		
14. INFORMANT (Address) <i>Rene C. La. Seckow Jackson Mo</i>		
15. FILED <i>101-1011</i> 19 <i>May 6</i> <i>Starkloff</i>		

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11 - 2 - 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 26, 1927*, to *Nov 2, 1927*, that I last saw him alive on *Nov 2, 1927*, and that death occurred, on the date stated above, at *1:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
126
95 B₂
Acute Dilatation of heart
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Operation Removal of Gall Bladder for Gallstones*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF WHAT PLACE OF DEATH?
 DID AN OPERATIVE PRECEDE DEATH? *yes* DATE OF *Oct 27 - 27*
 WAS THERE AN AUTOPSY? *yes*
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *W. A. Brown*, M. D.
 (Address) *Wall Bldg*

*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 <i>Jackson MO</i>	DATE OF BURIAL <i>Nov 5 1927</i>
20. UNDERTAKER <i>Cracraft & Miller</i>	ADDRESS <i>Jackson MO</i>

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.

DEPARTMENT RECORD

