DEC 27 1928

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

Do not use this space.

37235

1. PLACE OF DEATH
County Jackson — Registration District No. 407
Township E. Washington — Primary Registration District No. 555
City [redacted] (No. 9th & McGee St. Ward)

File No.
Registered No. 66

2. FULL NAME Albert D. Craig
(a) Residence. No. 9th & McGee St., Ward.
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Carrie Craig

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9 - 1872

7. AGE: Years 56 | Months 6 | Days 7 | If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN) —
(STATE OR COUNTRY) Illinois

PARENTS
10. NAME OF FATHER — Craig
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Not known
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) "

14. INFORMANT Elmer Craig
(Address) 444 Garfield Ave

15. FILED 11/17 1928 Fred R Kuehn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 16 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac
Age 60
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? no
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Leon Gashwiler, M. D.
, 19 (Address) Liberty Mo

*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: Pilot Grove - Mo — DATE OF BURIAL: Nov. 20 1928
20. UNDERTAKER: R. V. Lindsey & Sons Inc — ADDRESS: City

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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD