

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

Do not use this space.

29741

1. PLACE OF DEATH

County Saline Registration District No. 792
Township Arrow Rock Primary Registration District No. 6043 C
City (No.) St. Ward)

File No.

Registered No. 9

2. FULL NAME

Norman J. Craig

(a) Residence. No. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

Male White Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5 - 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 0 22

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Hugh Craig

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Canada

12. MAIDEN NAME OF MOTHER Elizabeth Wood

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

14. INFORMANT (Address) Hugh Craig
Arrow Rock Mo

15. FILED 8-30, 1929 Mrs. F. M. M. Morris REGISTRAR
Delo -

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-27 1929

17. I HEREBY CERTIFY, That I ~~attended~~ held inquest deceased from Aug 27, 1929 to —, 19—, and that I last saw h. alive on —, 19—, and that death occurred, on the date stated above, at — m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stroke Epilepticus

(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) — (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF X

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) B. C. Biddishead, M. D.

8-27, 1929 (Address) Arrow Rock Mo

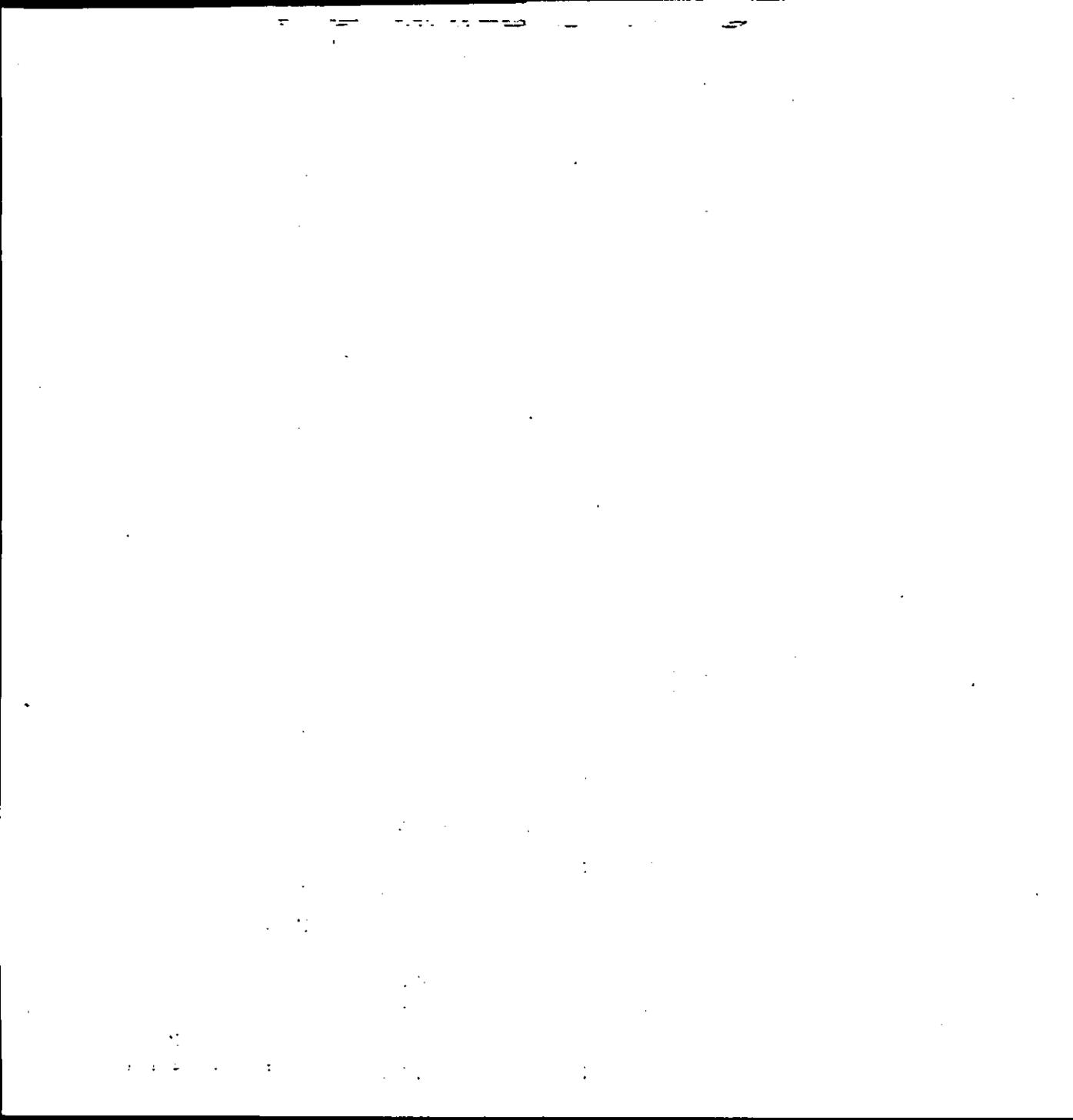
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Arrow Rock Cem. Aug 29 1929

20. UNDERTAKER ADDRESS

T. D. Campbell Marshall



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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 Township Arrow Rock Primary Registration District No. 6043 c Registered No. 9
 City (No. St. Ward)

2. FULL NAME

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 (a) Residence. No. 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 M 4. COLOR OR RACE W 5. SINGLE MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5 - 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 0 22

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(a) Trade, profession, or particular kind of work
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 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY)

14. INFORMANT
 (Address)

15. FILED Aug 29 1929 Mrs. Frances Moma REGISTRAR
Deputy

MEDICAL CERTIFICATE OF DEATH

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 that I last saw h..... alive on 19....., and that
 death occurred, on the date stated above, at

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

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

, 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

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SUPPLEMENTARY

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