

SEP 25 1930

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

Do not use this space.

27267

1. PLACE OF DEATH

County Macon Registration District No. 533  
Township Macon Primary Registration District No. 3027  
City Macon (No. ....) St. .... Ward)

File No. ....  
Registered No. 69

2. FULL NAME

Thomas A Craig  
(a) Residence. No. .... St. .... Wd. ....  
(Usual place of abode)  
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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

Male White

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

Hattie Craig

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 16 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
78 10 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Jeweler  
(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) England

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Robert Craig  
(Address) Macon, Mo.

15. FILED 8/30 1930 31 1/13 Pro Luke Funkler  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 1930

17. I HEREBY CERTIFY That I attended deceased from Aug 9 1930 to Aug 9 1930 that I last saw alive on Aug 9 1930 and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Fracture of skull -  
(accidental)  
2:10 P.M.  
(duration) ..... yrs. .... mos. 3 hrs

CONTRIBUTORY (SECONDARY) none  
(duration) ..... yrs. .... mos. .... da

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

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

WAS THERE AN AUTOPSY? .....

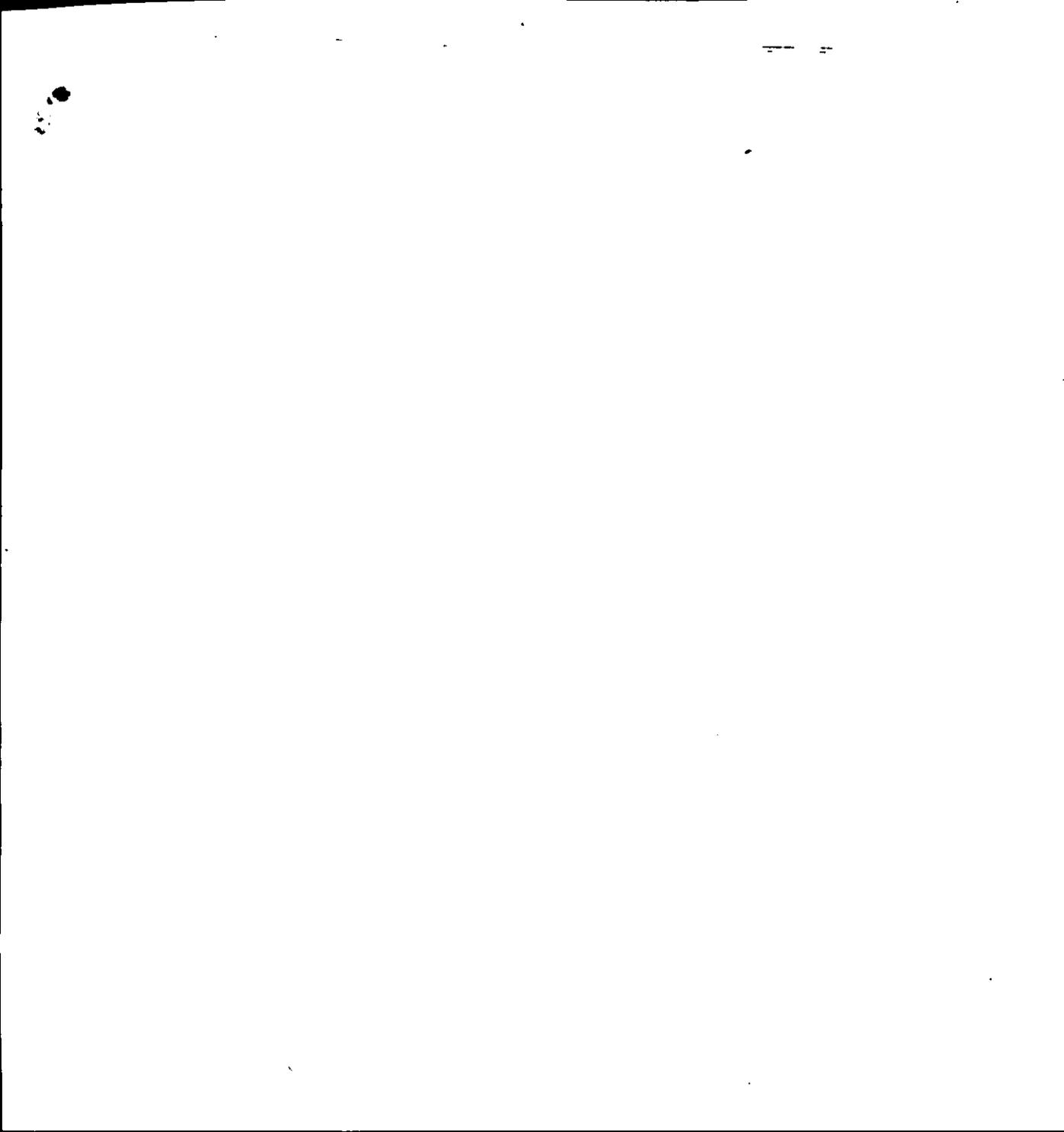
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. F. Turner, M. D.  
8/11, 1930 (Address) Macon 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 Cah. Wood DATE OF BURIAL 8/11 1930

20. UNDERTAKER Albert Skinner ADDRESS Macon Mo



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Macon Registration District No. 533 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3027 Registered No. 69  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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) M

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (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)

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 94 30 Mrs. Luke Lunkley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 1930

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_  
 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:**

Fracture of skull  
accidental, hit by  
car on highway 63.  
 (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)

\*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

20. UNDERTAKER ADDRESS

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS REGISTERED BY LAW

SUPPLEMENTARY

1877

33