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

17191

85

File No. 536

Registered No.

1. PLACE OF DEATH
County Buchanan
Registration District No.
Township
Primary Registration District No. 1001
City St Joseph Mo (No. State Hospital #2 St. Ward)

2. FULL NAME Robert McCracken
(a) Residence. No. Chillicothe Mo St., Ward. Chillicothe 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.

JUN 24 1931

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 Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1866

7. AGE: Years 65 Months 0 Days 0 If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN) Mo Unknown
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Lewis McCracken
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Mary Cloud
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFORMANT State Hospital Records
(Address) St Joseph Mo

15. FILED ..... 19.... John R Bender REGISTRAR
MAY 21 1931

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1931

17. I HEREBY CERTIFY, That I attended deceased from April 18, 1931, to May 19, 1931, that I last saw him alive on May 19, 1931, and that death occurred, on the date stated above, at 9 45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aortic Insufficiency
92A
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Chillicothe Mo
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings
(Signed) D S Miles, M. D.
May 19 1931 (Address) St Joseph 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 State Hospital Cemetery — DATE OF BURIAL May 22 1931
20. UNDERTAKER H D Dilenfaden — ADDRESS 1802 Lowson

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.

MARGIN RESERVED FOR BINDING