

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

Do not use this space.

14377

PLACE OF DEATH

County St. Louis Registration District No. 485
Township Brookhollow Primary Registration District No. 3037
City Hickwood Mo (No. 111 Couch Ave) St. _____ Ward _____

File No. _____
Registered No. 85
St. _____ Ward _____

2. FULL NAME Robert Howard Craig
(a) Residence. No. 111 Couch Ave St. _____ Ward. Hickwood 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 M. 4. COLOR OR RACE A. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-24-1871

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>61</u>	<u>10</u>	<u>17</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dry Goods man
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer See Stev A. G. Co

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

10. NAME OF FATHER Johnston Craig

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

12. MAIDEN NAME OF MOTHER Hickman

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

14. INFORMANT Emma E Craig (Address) 111 Couch Ave

15. FILED 4/13 1933 Cl Barnett M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-11 1933

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 4:37 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute endocarditis
(duration) _____ yrs. _____ mos. 7 ds.
CONTRIBUTORY (SECONDARY) Chronic nephritis
(duration) 5 yrs. _____ mos. _____ ds.

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

D DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS physical exam
(Signed) Walter L. Kelly, M. D.
, 19____ (Address) offton

*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 Oak Hill Cemetery DATE OF BURIAL 4-13 1933

20. UNDERTAKER Louis H. Bopp ADDRESS Hickwood Mo

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.

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APR 28 1933

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