

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

8022
 Do not use this space.

REC'D MAR 23 1939

1. PLACE OF DEATH *Stony*
 (a) County *Washington* Registration District No. *843*
 (b) Township *Washington* Primary Registration District No. *4513*
 (c) City *Galena* (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred *53* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME *Chas. H. Craig*

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *wh.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) *Marie Craig*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 26, 1875*
 7. AGE YEARS *64* MONTHS *10* DAYS *15* If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Pharmacist*
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) *April 1935* 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Milan, Mo.* 0
 FATHER 13. NAME *Wm Henry Craig* 9
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown* 1
 MOTHER 15. MAIDEN NAME *Amanda Burgess*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*
 17. INFORMANT *Marie Craig*
 (ADDRESS) *Galena, Mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Galena* DATE *1/2 1939*
 19. FUNERAL DIRECTOR (NAME) *Everett J. Cheatham*
 (ADDRESS) *Galena, Mo*
 20. FILED *Feb 11, 1939* *Tellie Ironby*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 10, 1939*
 22. I HEREBY CERTIFY, That I attended deceased from *Feb 6, 1939* to *Feb 10, 1939*
 I last saw him alive on *Feb 10, 1939*. Death is said to have occurred on the date stated above, at *12* m.
 The principal cause of death and related causes of importance were as follows:
Metabolic Coma
 59
 Other contributory causes of importance:
Renal Metastasis
 Name of operation _____ Date of _____
 What test confirmed diagnosis? *Autopsy* Was there an autopsy? *Yes*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. *Home*
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? *Yes*
 If so, specify _____ (Signed) *Pharmacy*, M. D.
 (Address) *Galena, Mo*

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.

RECEIVED

District Health Officer No. 6,

District File Number 6-39-249

Date Filed MAR 9 1939

APR 19 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Errett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Galena, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.