

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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NOV 14 1939

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

36094  
Do not use this space.

1. PLACE OF DEATH  
 (a) County GREENE Registration District No. 316  
 (b) Township Campbell Primary Registration District No. 2001 Registered No. 784  
 (c) City SPRINGFIELD (d) Street No. 904 W. Chase 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME WILLIAM HIRAM CRAIG  
 (a) Residence, No. 904 W. CHASE St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 21-1859

7. AGE YEARS 80 MONTHS 0 DAYS 4 IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

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)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

FATHER 13. NAME William Craig

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Martha M. Blakey

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Mrs. Yelpha Brannigan 904 W. Chase St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Roberson Prairie DATE 10-27-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wynn Funeral Springfield Mo

20. FILED Oct 27 1939 Chas A. Leonard Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 25 1939

22. I HEREBY CERTIFY, That I attended deceased from CRAIG July 17, 1934, to Oct 25, 1939  
 I last saw h. alive on Oct 24, 1939. Death is said to have occurred on the date stated above, at 11:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis  
Chronic Bronchial Asthma several years  
 Other contributory causes of importance:  
no  
 Name of operation no Date of  
 What test confirmed diagnosis clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury  
 Where did injury occur? no  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury no  
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no  
 (So, specify (Signed) J. F. Freeman, M. D.  
 (Address) Springfield Mo

**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 Gayd W. Ford

Licensed Embalmer No. 2910

P. O. Address 629 W. Walnut

**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.**

X