No. 2
-1-4-41
5-17-39
I X25390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED SEP 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28170

Registration District No. 241 Primary Registration District No. 5334 Registrar's No. 1294

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Rural S. Benton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Buffalo Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Buffalo Mo.
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Loren O. Craig

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced M I

6. (b) Name of husband or wife Angeline Craig

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased 11 (Month) 20 (Day) 1872 (Year)

8. AGE: Years 68 Months 8 Days 29 If less than one day ..... hr. ..... min.

9. Birthplace Dallas Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name Unknown
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant Arlo Craig
(b) Address Buffalo Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-41 (Month) (Day) (Year)
(c) Place: burial or cremation Prairie Grove

18. (a) Signature of funeral director L. B. Jones
(b) Address Buffalo Mo.

19. (a) ..... (Date received local registrar) (b) Harvey Morrow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 19 year 1941 hour 5 minute a M.

21. I hereby certify that I attended the deceased from 8-14- 1941, to 8-19- 1941; that I last saw him alive on 8-14 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Heart disease	20 yrs
Due to Chronic Polyarthritis	25 yrs
Due to	
Other conditions Acute Gall bladder (Include pregnancy within 3 months of death)	5 days

Major findings:
Of operations None
Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) ..... (County) ..... (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature G. L. Plummer (M. D. or other) MD
Address Buffalo Date signed 8-4-41

215 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 9-41-1685
Date Filed 9-15-41

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 Clyde Montgomery
Licensed Embalmer No. 3592
P. O. Address Buffalo 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, fact should be so stated above.

S. No. 2B
1—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28170

Registration District No. 241 Primary Registration District No. 5334 Registrar's No. 1694

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Buffalo, Mo.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Rural S. Benton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Buffalo Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Loren O. Craig

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18
year 1941 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Heart disease	
Due to Chronic Poly arthritis	
Due to	
Other conditions Acute gall bladder (Include pregnancy within 3 months of death)	✓

Major findings:
Of operations Acute
Of autopsy 127a

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

. No. 2B
—8-21-41
I X29288

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(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Loren A. Craig

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased ..... (Month) ..... (Day) ..... (Year)

8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 9-19-41 (Date received local registrar) (b) Harry Monroe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19 year 1941 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw him alive on ..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) ..... (County) ..... (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY