S. No. 2
M—5-42
5-17-39
I X3267

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

7388

State File No.

FILED MAR 13 1943

Registration District No. 7297

Primary Registration District No. 6022

Registrar's No. 10

1. PLACE OF DEATH:

(a) County: Ray

(b) City or town: Richmond, rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: South of Richmond (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Ray

(c) City or town: Richmond, rural (If outside city or town limits, write "RURAL")

(d) Street No.: South of Richmond. (If rural, give location)

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

3. (a) PRINT FULL NAME: JAMES R. CRAVEN

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Minerva J. Craven

6. (c) Age of husband or wife if alive: 73 years

7. Birth date of deceased: February 1, 1861 (Month) (Day) (Year)

8. AGE: Years 81 Months 0 Days 28 If less than one day hr. min.

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

10. Usual occupation: Farming

11. Industry or business:

FATHER 12. Name: James Craven

13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Margaret Clark

15. Birthplace: Quincy, (City, town, or county) Illinois (State or foreign country)

16. (a) Informant: Mrs. Roscoe Douglas

(b) Address: Henrietta, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-25-1943 (Month) (Day) (Year)

(c) Place: burial or cremation: Orrick, Missouri

18. (a) Signature of funeral director: [illegible]

(b) Address: Richmond, Missouri

19. (a) 7/25 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 23rd year 1943 hour 9:20 minute A. M.

21. I hereby certify that I attended the deceased from Jan 11 1943 to Feb 22 1943 that I last saw him alive on Feb 22 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia

Due to: Arteriosclerosis

Due to:

Other conditions (Include pregnancy within 3 months of death): Chronic Nephritis

Major findings: Of operations: —

Of autopsy: — 108

Duration

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: [illegible] (M. D. or other)

Address: Richmond Date signed: 5-25-43

1200

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number .....

Date Filed 3-12-43

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 E. S. Hinsman

Licensed Embalmer No. 2073

P. O. Address Richmond, 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.

V. S. No. 2B
10M—8-21-41
P I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7388

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 10

1. PLACE OF DEATH:

(a) County Ray

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

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

(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 James R. Craven

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 Feb. (Month) 1 (Day) 1860 (Year)

8. AGE: Years 81 Months 0 Days 22 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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) Feb 25 1943 (Date received local registrar) (b) (Mrs Chas W Shepard) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23 year 1943 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 Lobar Pneumonia — Duration

Due to arteriosclerosis cerebral hemorrhage

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