

FILED APR 27 1943

Registration District No. 34 D

Primary Registration District No. 6142

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Revere Mo. R2  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Liberty Imp.  
(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) 1 Wk

2. USUAL RESIDENCE OF DECEASED:

(a) State Ark (b) County Greene

(c) City or town Marmaduke Ark R30  
(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 SAMUEL ELI CRAIG

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 2-10-1943 to 2-10-43  
that I last saw him alive on 2-10-43 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife VINA CRAIG 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased APRIL 23 1872  
(Month) (Day) (Year)

Immediate cause of death apoplexy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) g3a

8. AGE: Years 70 Months 9 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name Charley Craig

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

14. Maiden name Marganda Prator

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

16. (a) Informant Lee Crouch

(b) Address Marmaduke Ark R30

17. (a) Burial (b) Date thereof 2/14/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hawyers Chapel

18. (a) Signature of funeral director W. H. Bishop

(b) Address Rector, Ark

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Hawyers Ryan (M. D. or other) \_\_\_\_\_  
Address Revere Mo Date signed 2-12-43

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

103  
0  
0

JUN 8 1943

MAR 22 1943

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 340

Primary Registration District No. 610-2

Registrar's No. 21

1. PLACE OF DEATH: Stoddard  
 (a) County.....  
 (b) City or town.....  
 (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  
 In this community..... years, months or days)

3. (a) PRINT FULL NAME: Samuel Eli. 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: April 23 1874  
 (Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 14 (If less than one day) min.

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

10. Usual occupation.....

11. Industry of business.....

MOTHER FATHER { 12. Name.....  
 13. Birthplace (City, town, or county) (State or foreign country)  
 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) 5-3-43 (b) Cardie Miller  
 (Date received local registrar) (Registrar's signature)

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.....

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.....  
 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?  
 While at work?..... (Specify type of place) (e) Means of injury.....

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

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

SUPPLEMENTARY

JUN 8 10 43

S-11654