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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 12 1943

Registration District No. 58

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5201

State File No. 24627

Registrar's No.

1. PLACE OF DEATH:

(a) County CARROLL

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

(c) Name of hospital or institution: Dewitt Twp
(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 CARROLL 17

(c) City or town BOSWORTH MO 0
(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 0

3. (a) PRINT FULL NAME REBECCA CRAIG

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Deceased

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

7. Birth date of deceased OCT (Month) 26 (Day) 1862 (Year)

8. AGE:

Years	Months	Days	If less than one day
80	8	26	hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name WILLIAM WHARTON
13. Birthplace (City, town, or county) IRELAND 4 (State or foreign country)

MOTHER
14. Maiden name MARY STEVENS
15. Birthplace (City, town, or county) IRELAND 4 (State or foreign country)

16. (a) Informant Geo CRAIG
(b) Address BOSWORTH MO

17. (a) (Burial, cremation, or removal) (b) Date thereof JULY (Month) 24 (Day) 1943 (Year)
(c) Place: burial or cremation WHARTON Cemetery

18. (a) Signature of funeral director David J. Edwards
(b) Address Bosworth MO

19. (a) July 26 1943 (Date received local registrar) (b) Hester Fisher (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 22
year 1943 hour 4:15 minute P M

21. I hereby certify that I attended the deceased from Dec 1941, 1941, to Jul 22, 1943
that I last saw her alive on Jul 22, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial

Due to Infected Fracture Head of Femur

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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) M.D.
Address Bosworth MO Date signed Jul 26 43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer
District File Number
Date Filed

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 David J. Edwards

Licensed Embalmer No. 3265

P. O. Address Bosworth Me

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

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. AUG 13 19

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Bosworth Mo
(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)

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 Rebecca Craig

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

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

4. Sex F

5. Color or race W

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

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 July day 22
year 1943 hour 4 P minute P 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.

Immediate cause of death Myocarditis

Due to Infected Fracture head of Femur

Due to .....

Other conditions ..... (Include pregnancy within 3 months of death)

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

Duration

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

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Fracture Femur

(b) Date of occurrence Nov 1941

(c) Where did injury occur? at Residence Carroll Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes Yes Yes (Specify type of place)

While at work? Yes (e) Means of injury .....

23. Signature A. J. Boas Brown (M. D. or other)

Address Bosworth Mo Date signed Aug 11/43

5-24627