

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14031

FILED MAY 8 1944

Registration District No. 8000

Primary Registration District No. 3005

Registrar's No. 32

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

1. PLACE OF DEATH:

(a) County Bates

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

(c) Name of hospital or institution: Butler Memorial Hospital 0  
(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 Missouri (b) County Bates 7

(c) City or town Butler  
(If outside city or town limits, write "RURAL") 1

(d) Street No. \_\_\_\_\_  
(If rural, give location) 1

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Walter Craig

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25 year 1944 hour 4 minute past M.

4. Sex male 0 5. Color or race white

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

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

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

7. Birth date of deceased: June 3 1892  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr 21 1944 to Apr 25 1944 that I last saw him alive on Apr 25 and that death occurred on the date and hour stated above.

Immediate cause of death: staph pneumonia

Duration \_\_\_\_\_

8. AGE: Years 61 Months 10 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death) 108

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

10. Usual occupation Retired Farmer

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name John H Craig

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

14. Maiden name Margaret Gunn

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

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? \_\_\_\_\_

16. (a) Informant Mrs Bob. Rose

(b) Address Butler mo

17. (a) Burial (b) Date thereof April 27 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smith

18. (a) Signature of funeral director Cubers

(b) Address Butler mo

19. (a) 4-26-44 (b) Paul C. Cumpton  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_

While at work \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature P. D. ... (M. D. or other) \_\_\_\_\_

Address Butler mo Date signed 4-26-44

1326

RECEIVED

District Health Officer No. 7,

District File Number

4-44-596

Date Filed

5-6-44

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

*C. E. Culum*

Licensed Embalmer No.

2576

P. O. Address

*Butler, 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.