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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 19 1945

Registration District No. 13

Primary Registration District No. 3003

Registrar's No. 10

1. PLACE OF DEATH:

(a) County BARRY

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

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

(d) Length of stay: In hospital or institution.....  
In this community..... 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON 73

(c) City or town GRANBY RURAL 0  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME ALICE CRATON

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 29  
year 1945 hour 6 minute P M.

21. I hereby certify that I attended the deceased from Jan 22  
1945, to Jan 29 1945  
that I last saw h. or alive on Jan 29 1945  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, W. dow

6. (b) Name of husband or wife George Craton 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased JAN 27 1871  
(Month) (Day) (Year)

Immediate cause of death  
Chronic nephritis  
arterio-sclerotic kidney Duration years

Due to.....

Due to.....

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

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

74 2 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Lewis C Ferguson

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

14. Maiden name Marcy Stewart

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

16. (a) Informant Dr L. H. Ferguson

(b) Address Monett Mo

17. (a) Removal (b) Date thereof 1-29-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newtonia Missouri

18. (a) Signature of funeral director Ja. Bishop

(b) Address Neosho Missouri

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

Major findings:  
Of operations..... 131

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?..... (c) Means of injury.....

23. Signature Frank R. ... (M. D. or other) 0

Address Monett Mo Date signed 1/29/45

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

1300

RECEIVED

District Health Officer No. 67

District File Number 245-191

Date Filed FFR 8 1915

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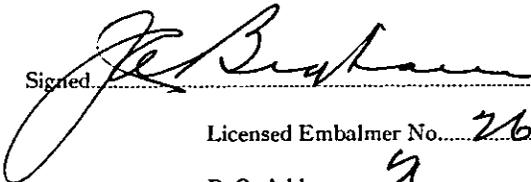
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STATEMENT BY LICENSED EMBALMER

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. 2689

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.

Registration District No. 13

Primary Registration District No. 3003

Registrar's No. 10

**1. PLACE OF DEATH:**  
 (a) County Barry  
 (b) City or town month  
 (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** Abie Craton  
 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 Jan 27 (Month) (Day) (Year)

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) Rudna Willoughby (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 June Day 27 Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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

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

MOTHER FATHER

1601