V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18042

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1264

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton, Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Co. Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5-12-45 to 5-31-45 (Specify whether In this community 1 1/2 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Riverview Gardens (If outside city or town limits, write "RURAL")
(d) Street No. 347 Fork Drive (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles E. Craig
3. (b) If veteran, name war Nil
3. (c) Social Security No. None
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced widower
6. (b) Name of husband or wife Annie Brubaker Craig
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased 2 (Month) 24 (Day) 76 (Year)

8. AGE: Years 69 Months 3 Days 7 If less than one day hr. min.

9. Birthplace Marion Co (City, town, or county) Ill. (State or foreign country)
10. Usual occupation none
11. Industry or business none
FATHER
12. Name George Craig
13. Birthplace ? (City, town, or county) Illinois (State or foreign country)
MOTHER
14. Maiden name Matilda Linder
15. Birthplace ? (City, town, or county) Illinois (State or foreign country)
16. (a) Informant Cullen T. Lawson (Bro-in-law)
(b) Address 347 Fork Dr., Riverview Gardens
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Xenia, Illinois
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) JUN 4 1945 (Date received local registrar) (b) E. B. McPherson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 31 year 1945 hour 6 minute 25 P.M.
21. I hereby certify that I attended the deceased from 5-12, 1945, to 5-31, 1945; that I last saw him alive on 5-31, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Due to arteriosclerosis cordia-renal-vascular disease
Due to 131a
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 Wm Morrissey M.D. (or other)
Address St Louis County Resp Date signed 6-1-45

(Licensed Embalmer's Statement on Reverse Side)

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.