

No. 2  
-5-43  
-17-39  
X38671

State File No. ....

**FILED** JAN 12 1946

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 334

**1. PLACE OF DEATH:**

(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
905 Park Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 45 Years  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Boone /  
(c) City or town Columbia /  
(If outside city or town limits, write "RURAL")  
(d) Street No. 905 Park Ave. /  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CARRIE BELL CRAIGO

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White  
6. (a) Single, widowed, married, divorced Single /  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 11 - 2 - 1884  
(Month) (Day) (Year)

8. AGE: Years 61 Months 1 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Robert William Craigo  
13. Birthplace Fulton Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Annie Barbara Speece  
15. Birthplace Lancaster Pa.  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Ruth Craigo  
(b) Address 905 Park Ave., Columbia, Mo.  
17. (a) Burial (b) Date thereof 12-27-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Parker Funeral Service  
(b) Address Columbia, Mo.  
19. (a) 12-28-45 (b) Mrs R E Palmer  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 23  
year 1945 hour 10 minute 15 A. M.

21. I hereby certify that I attended the deceased from one day  
22 - 1945 to Dec 22 - 1945  
that I last saw h. alive on Dec 22 - 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Pancreas Duration No not known  
Operated for who says

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

Due to \_\_\_\_\_ 46g  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: As above  
Of operations \_\_\_\_\_  
Of autopsy Yes

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? No (Specify type of place) Means of injury \_\_\_\_\_  
23. Signature W. P. ... (M. D. or other) \_\_\_\_\_  
Address Collected Date signed 12/27/45

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

RECEIVED

District Health Officer No: 9,

District File Number.....

Date Filed 1-11-46

JAN 14 1946

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.....

working under my personal supervision.

..... Registered Apprentice No.....

Signed

*M. D. Whitfield*

Licensed Embalmer No. 3893

P. O. Address Calumet

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.