S. No. 2
OM—5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 10 1946

State File No. 26547

Registration District No. 59 Primary Registration District No. 5224 Registrar's No. 127

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

25393

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Rural Grandriver (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5 M. West of Harrisonville (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution At Home (Specify whether
In this community 3 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cass 19
(c) City or town Rural 0 (If outside city or town limits, write "RURAL")
(d) Street No. 5 M. West of Harrisonville (If rural, give location)
(e) Citizen of foreign country? No ~~(Yes or No)~~
If yes, name country

3. (a) PRINT FULL NAME John Buckner McCraw.
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of ~~husband~~ or wife Lillie B. Drury.
6. (c) Age of ~~husband~~ or wife if alive 69 years
7. Birth date of deceased Jan (Month) 14 (Day) 1974 (Year)

8. AGE: Years 72 Months 7 Days 16 If less than one day hr. min.

9. Birthplace Near Adrian (City, town, or county) Bates Co. Mo. (State or foreign country)
10. Usual occupation Farmer (active)
11. Industry or business
FATHER
12. Name Samuel J. McCraw.
13. Birthplace Bates Co. Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Tobie Hammontree
15. Birthplace Cass Co. Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Lillie McCraw.
(b) Address Harrisonville, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-46 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Crescent Hill Cemetery
18. (a) Signature of funeral director Atkinson Bros.
(b) Address Harrisonville Mo.
19. (a) Aug 31-1946 (Date received local registrar) (b) Laura J. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1946 hour 5 minute 00 P.M.
21. I hereby certify that I attended the deceased from June, 1946 to Aug 30, 1946 that I last saw him alive on 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	5 min
Due to: Duodenal Ulcers	5 mos.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 117 R
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? (e) Means of injury

23. Signature Dr C. E. Everett (M. D. or other) D.O.
Address Harrisonville, Mo Date signed 8/31/46

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(Licensed Embalmer's Statement on Reverse Side)

12435

MAR 24 1947

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 Floyd A. Brinson

Licensed Embalmer No. 3920

P. O. Address Harrisonville

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.