

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38510**

FILED DEC 9 1946
Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **0210**

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Barnes Hospital, O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 204 E. Davis st.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Newton Craig

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

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Minnie Craig 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 2 1872
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27
year 1946 hour 10 minute P M.

21. I hereby certify that I attended the deceased from November 10, 1946 to November 27, 1946
that I last saw him alive on November 27, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolus Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>7</u>	<u>25</u>	_____ hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation Elevator Operator

Other conditions Salmonella enteritis
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of prostate

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Of operations _____

Of autopsy _____

16. (a) Informant George F. Tennison

(b) Address 5015 Steffens ave.

17. (a) Burial (b) Date thereof Nov. 30-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Trinity Cemetery

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? _____

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 7814 S. Broadway

19. (a) Nov 30 1946 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature JR Prader (M. D. number) _____

Address Barnes H. Date signed 11-28-46

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

MOTHER FATHER

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..... *John Ketter*

..... Licensed Embalmer No..... *3880*

..... P. O. Address..... *St. Louis 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.