

S. No. 2
2-43
5-17-39
7823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1947

Registration District No. 201

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 435

5434

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Zabala
(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 2 1/2 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Talbert Rockwell Cragg
(b) If veteran, name war 2
(c) Social Security No. 2

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 12 years (Day) (Year)

7. Birth date of deceased July 12 - 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 4 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business
12. Name Washington Cragg
13. Birthplace Lebanon Mo (City, town, or county) (State or foreign country)
14. Maiden name Harvey Gene Myers
15. Birthplace Lebanon Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs J. A. Cragg
(b) Address 4015 7 air 25 St Macon Mo

17. (a) Burial (b) Date thereof Feb 18 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zabala

18. (a) Signature of funeral director J. P. Christie
(b) Address Zabala Mo

19. (a) 2-19-47 (b) Mrs O B Griffin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County macon
(c) City or town Zabala
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Feb day 16 year 1947 hour 10 minute 30 A.M.
21. I hereby certify that I attended the deceased from Dec 9 to Feb 16 1947
that I last saw him alive on Feb 16 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma of prostate
Due to Sarcoma of prostate
Due to

Duration
1 year
"

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
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?

23. Signature Joseph Gullett Jr (M. D. or other) Dr
Address Zabala Mo Date signed 2/16/47
While at work (Specify type of place) (c) Means of injury

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

MOTHER FATHER

180

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number - 3-47-502
MAR 1 1947
Date

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 D. S. Kristie
Licensed Embalmer No. 1109
P. O. Address La Plata 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 201

Primary Registration District No. 4315

Registrar's No.

1. PLACE OF DEATH:
 (a) County Mocon
 (b) City or town La Plata
(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)

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.....

3. (a) PRINT FULL NAME Albert R. Shagg
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month.....
 year 1947 hour..... minute..... M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced unmarried
 6. (b) Name of husband or wife Ira Belle Shagg 6. (c) Age of husband or wife if alive.....
 7. Birth date of deceased.....
(Month) (Day) (Year)
 8. AGE: Years 80 Months..... Days.....
(less than one day)
 hr. min.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.
 Immediate cause of death.....
 Due to.....
 Due to.....

9. Birthplace.....
(City, town, or county) (State or foreign country)
 10. Usual occupation.....
 11. Industry or business.....
 MOTHER FATHER { 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)

Other conditions.....
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy.....
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant..... (b) Address.....
 17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....
 18. (a) Signature of funeral director..... (b) Address.....
 19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

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.....

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

SUPPLEMENTARY

S-5434