

1-147  
-17-39

FILED NOV 10 1948

347

Primary Registration District No. 4508

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Stone

(b) City or town Galena  
(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 years, months or days) about 61 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone

(c) City or town Galena  
(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 John Craig

3. (b) If veteran, name war no

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24  
year 1948 hour 10 minute AM

4. Sex M 5. Color or race wh 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Emma Craig 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased July 2 1873  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1 Oct 1948, to 10 Oct 1948  
that I last saw her alive on 10 Oct and that death occurred on the date and hour stated above.

Immediate cause of death Angin Pectoris -

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>3</u>	<u>23</u>	_____ hr. _____ min.

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations 9.4.12  
Of autopsy \_\_\_\_\_

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

10. Usual occupation merchant

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

12. Name William Craig

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

14. Maiden name Amanda Burgess

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

16. (a) Informant Mrs. Barnett Cole  
(b) Address Galena Mo

17. (a) burial (b) Date thereon Oct 26 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galena Cemetery

18. (a) Signature of funeral director Ernest Cheatham  
(b) Address Galena Mo

19. (a) Oct 26 48 (b) Lena Murray - Dep.  
(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 Josephine (M. D. or other) \_\_\_\_\_  
Address Galena Mo Date signed 25 Oct 48

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6;

District File Number 1148-1271

Date Filed 11-9-48

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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 Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Halena 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. 22  
Registrar's No. 54

Registration District No. 347 Primary Registration District No. 4508

1. PLACE OF DEATH:  
(a) County Stone  
(b) City or town Galena  
(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

3. (a) PRINT FULL NAME John Craig  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color of hair W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 2 (Month) 1914 (Day) 1914 (Year)

8. AGE: Years 75 Months 3 Days 10 (less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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)

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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Stone  
(c) City or town Galena (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July Year 1914 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (Specify type of place) (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-35352 -