

FILED MAR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5788

85-9

BIRTH NO. _____ REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 4427 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Waynesville</u> c. LENGTH OF STAY (in this place) <u>3 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De Witt Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>Near Cook Station</u>	
3. NAME OF DECEASED (Type or Print) <u>William Andrew Craig</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. - 12 - 1949</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>January, 1881</u>
9. AGE (In years last birthday) <u>68</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Craig</u>		13b. MOTHER'S MAIDEN NAME <u>Cannon</u>	
14. NAME OF HUSBAND OR WIFE <u>Edith M. Craig</u>		15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>499-38-8927</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>L. Edward Craig St. Louis Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paralytic ileus with complete obstruction</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> ANTECEDENT CAUSES DUE TO (b) <u>Generalized peritonitis</u> <u>2 weeks</u> DUE TO (c) <u>Dramplic obstruction</u> <u>3 weeks</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>5705</u>	
19a. DATE OF OPERATION <u>2-1-49</u> <u>1:24-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Intestinal obstruction adhesions</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-29</u> , 19 <u>49</u> , to <u>2-12</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2-12</u> , 19 <u>49</u> , and that death occurred at <u>8:40 P.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Edward J. Decker</u> (Degree or title) <u>DO.</u>		23b. ADDRESS <u>Waynesville, Mo.</u>	
23c. DATE SIGNED <u>2-26-49.</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb 14, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Salem Mo.</u>	
DATE REC'D BY LOCAL REG. <u>March 8, 1949</u>		REGISTRAR'S SIGNATURE <u>Thelma C. Buckthorpe</u> 289	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Hobson & Chantman</u>		ADDRESS <u>Salem Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Edward F. Broyles*

Licensed Embalmer No. *4553*

P. O. Address *Salem, Miss.*

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.