

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23067

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 641

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) SPRINGFIELD 30	
c. LENGTH OF STAY (In this place) 34 yrs.		d. STREET ADDRESS (If rural, give location) 1815 W. THOMAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1815 W. THOMAN		d. STREET ADDRESS (If rural, give location) 1815 W. THOMAN	
3. NAME OF DECEASED (Type or Print) a. (First) GUY		b. (Middle) THOMAS	
c. (Last) CRAIG		4. DATE OF DEATH (Month) (Day) (Year) JULY 19 1949	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT. 5, 1894
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER	
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME WILLIAM CRAIG		13b. MOTHER'S MAIDEN NAME LUCINDA VICKERS	
14. NAME OF HUSBAND OR WIFE IDA CRAIG		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. 500-10-2605		17. INFORMANT'S SIGNATURE OR NAME ADDRESS IDA CRAIG SPRGFD. MO.	
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) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardis DUE TO (c) Vasculis Disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 July 19 1949 , to July 19 1949 , that I last saw the deceased alive on July 19 1949 , and that death occurred at 9 A. m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Edward Marcus D.M.		23b. ADDRESS 623 Woodruff Bldg	
23c. DATE SIGNED 7/19/49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 7-21-49		24c. NAME OF CEMETERY OR CREMATORY ROBERSON PRAIRIE	
24d. LOCATION (City, town, or county) (State) NEAR SPRINGFIELD, MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Klingner + Co. Spgfd. Mo.	
DATE REC'D BY LOCAL REG 7-22-49		REGISTRAR'S SIGNATURE W.S. Landby M.D.	

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.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No. 40710

P. O. Address _____

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.