

FILED OCT 13 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **34699**

BIRTH NO. \_\_\_\_\_

REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **8441**

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>4 da.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Licking</u>		1070
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>St. Louis Childrens Hosp.</u>			d. STREET ADDRESS (If rural, give location) <u>1</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>GRANVILLE</u>		b. (Middle) <u>WAYNE</u>	c. (Last) <u>CRAIG</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-6-50</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>8-20-43</u>	9. AGE (In years last birthday) <u>7 yrs</u>	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Licking, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Hubert H. Craig</u>		13b. MOTHER'S MAIDEN NAME <u>Georgie Smith</u>		14. NAME OF HUSBAND OR WIFE <u>nil</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>B. Salantai</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>Cerebellar tumor; type known.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pendymoma, non malignant</u>		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>10-5-50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Craniotomy - 4<sup>th</sup> ventricle tumor (Brain)</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) m. <u>10-5-50 4:40</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>A - V</u>		
22. I hereby certify that I attended the deceased from <u>10-2</u> , 19 <u>50</u> , to <u>10-6</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10-6</u> , 19 <u>50</u> and that death occurred at <u>12:30</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Dr. L. Johnston, M.D.</u>			23b. ADDRESS <u>Childrens Hospital</u>		23c. DATE SIGNED <u>10-6-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>10-6-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Craddock Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Licking Missouri</u>	
DATE REC'D BY LOCAL REG. <u>OCT 6 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Sarater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 18 1950

**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 Me

working under my personal supervision.

Student Embalmer No. ....

Signed Edson R. H. Remelius

Signed .....  
Student Embalmer

Licensed Embalmer No. 4283

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.