

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24852**

DEAD JUL 29 1952

BIRTH NO. _____		REG. DIST. NO. <u>155</u>		PRIMARY REG. DIST. NO. <u>3127</u>		Registrar's No. <u>114</u>	
1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webb City</u>		c. LENGTH OF STAY (in this place) <u>10 Years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webb City</u> <u>0472</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jane Chinn Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>320 S. Tom St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Homer</u>		b. (Middle) <u>James</u>		c. (Last) <u>Craker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 18, 1952</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 12, 1912</u>	
9. AGE (In years last birthday) <u>40</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Store Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years) IF UNDER 1 YEAR: Months <u>4</u> Days <u>6</u> IF UNDER 24 HRS.: Hours <u> </u> Mins. <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Aurora, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>F.L. Craker</u>			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE <u>Alpha Craker</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.		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs. Alpha Craker 320 S. Tom St. Webb City, 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>Streptococcic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Streptococcic Throat Infection</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>051X</u>				20. AUTOPSY? YES <input checked="" 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) (Min.)		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>7/17/1952</u> , to <u>7/18/1952</u> , that I last saw the deceased alive on <u>7/18/52</u> , 19 <u> </u> , and that death occurred at <u>6:30A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm Webb-Preb</u>				23b. ADDRESS <u>802 24th W. Davenport Webb City, Mo.</u>		23c. DATE SIGNED <u>7/21/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-21-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Webb City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-21-52</u>		REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switzer</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Johnston-Arnee-Simpson, Webb City, Mo Mortuary</u>			

(Licensed Embalmers' Statement on Reverse Side)

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

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RECEIVED 7-28-52
Jasper County Health Office

County File Number 52/7/596
Date Filed 7-28-52

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 Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address Webb City, 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.