No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21430

State File No. .....

FILED JUL 13 1953

BIRTH NO. ..... REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 8

+61

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Plains
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Christa Hogan Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Oregon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Thayer
d. STREET ADDRESS (If rural, give location): 073 ...

3. NAME OF DECEASED (Type or Print)
a. (First): ETHEL
b. (Middle): A.
c. (Last): McCRACKEN

4. DATE OF DEATH (Month) (Day) (Year): June 17, 1953

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: Feb. 25, 1879
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Hiawatha, Kansas
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Frank Ford
13b. MOTHER'S MAIDEN NAME: Emily Meers
14. NAME OF HUSBAND OR WIFE: Elbert McCracken, ddc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Herbert Burke — ADDRESS: Camp, Ark.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
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:
19b. MAJOR FINDINGS OF OPERATION: 4222
20. AUTOPSY? YES ☐ NO ☐

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.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-15, 1953, *to* 6-17, 1953, *that I last saw the deceased alive on* 6-17, 1953, *and that death occurred at* 3:05 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. P. Callihan M. D.
23b. ADDRESS: West Plains, Missouri
23c. DATE SIGNED: 6/24/53

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 6/21/53
24c. NAME OF CEMETERY OR CREMATORY: Camp Cemetery
24d. LOCATION (City, town, or county) (State): Camp, Ark.

DATE REC'D BY LOCAL REG.: 7-9-53
REGISTRAR'S SIGNATURE: Beatrice Cook 379
25. FUNERAL DIRECTOR'S SIGNATURE: Leland Curtis — ADDRESS: Thayer Mo

(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 _____

Licensed Embalmer No. 4516

P. O. Address Thayer, 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.