

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45700

State File No. _____

BIRTH NO. FILED APR 6 1954 REG. DIST. NO. 134 PRIMARY REG. DIST. NO. 4209 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mt. Moriah		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mt. Moriah	
c. LENGTH OF STAY (in this place) All life		d. STREET ADDRESS (If rural, give location) 0 410 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) Albert	b. (Middle) -----	c. (Last) Craig	4. DATE OF DEATH (Month) (Day) (Year) October 9 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 28 1866	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY General farming	11. BIRTHPLACE (State or foreign country) Harrison Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Alexander Craig	13b. MOTHER'S MAIDEN NAME Christena Anderson	14. NAME OF HUSBAND OR WIFE Elizabeth Craig (Deceased)
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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. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Cole Rhea	ADDRESS Mt. Moriah, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Years Ago
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Pericarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rheumatic Fever DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 416 X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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
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22. I hereby certify that I attended the deceased from Oct 4 1953 to Oct 9 1953, that I last saw the deceased alive on Oct 9 1953, and that death occurred at 11:30 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) G. Sellers M. D.	23b. ADDRESS Mt. Moriah, Mo.	23c. DATE SIGNED 10/10/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 12 1953	24c. NAME OF CEMETERY OR CREMATORY Ridgeway Cemetery	24d. LOCATION (City, town, or county) (State) Ridgeway, Mo.
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DATE REC'D BY LOCAL REG. April 1-54	REGISTRAR'S SIGNATURE S. H. Shaw	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Cainsville, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
00. 48

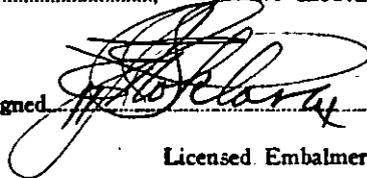
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, of Mo

Student Embalmer No. _____

working under my personal supervision.

Signed _____



Signed _____
Student Embalmer

Licensed Embalmer No. 3602

P. O. Address Gainsville, 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.