

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29685

FILED OCT 10 1956

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 306

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Com. N. Home # 1</u>			Length of stay in 1b <u>3 days</u>		d. STREET ADDRESS (If outside, give location) <u>208 S. Mulanix</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Clem</u> Middle _____ Last <u>Craig</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1956</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/16/1870</u>		9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Groceryman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Food Distr.</u>			11. BIRTHPLACE (City and state or country) <u>Nakomis, Ill.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>James W. Graig</u>						14. MOTHER'S MAIDEN NAME <u>Louisa (unknown)</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Clem Craig, Kirksville, Mo.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u> DUE TO (b) <u>Circulatory Collapse</u> DUE TO (c) <u>Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, Atherosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>4201</u>												
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE	
21. I attended the deceased from <u>Sept 2, 1956</u> to <u>Oct 1, 1956</u> and last saw ^{her} him alive on <u>Oct 1, 1956</u> Death occurred at <u>12:45 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>George H. Scherer D.O.</u> (Degree or title)						22b. ADDRESS <u>Kirksville, Mo.</u>						22c. DATE SIGNED <u>Oct 1, 1956</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/3/56</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Highland Park Cent</u>				23d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>							
24. FUNERAL DIRECTOR <u>Davis & Davis</u> ADDRESS <u>Kirksville</u>				25. DATE RECD. BY LOCAL REG. <u>10-5-56</u>				26. REGISTRAR'S SIGNATURE <u>Kate Lambert</u>							

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.....
Signature of Student Embalmer

Signed *Kenneth R. King*.....

Licensed Embalmer No. *41*.....

P. O. Address *Kirkwood*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.