

FILED NOV 20 1956

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH40363
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>360</u>		PRIMARY REG. DIST. NO. <u>3076</u>		Registrar's No. <u>217</u>	
1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Nevada</u>		c. LENGTH OF STAY (in this place) <u>50 yrs</u>		c. CITY OR TOWN <u>Nevada</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Welfall Nursing Home</u> <u>402 No. Cedar St</u>				e. STREET ADDRESS (If rural, give location) <u>402 North Cedar St</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Wesley</u>		b. (Middle) <u>Alfred</u>		c. (Last) <u>Craighead</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11-14-1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>March 18-1884</u>	
9. AGE (In years last birthday) <u>72</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, or, if retired) <u>ex-police chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Callaway Co., Mo.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Alfred Craighead</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Clingman</u>	
14. NAME OF HUSBAND OR WIFE <u>deceased</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, if unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>487-38-907</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hazel Hoggard</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>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Previous Cerebral Hemorrhage</u> DUE TO (c) <u>331X-</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Had rather severe attack of Hiccoughs for 3 or 4 days before death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days about a year ago</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <u>none</u> (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Nevada - Vernon - Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>January 1916</u> , to <u>Nov 14, 1956</u> , that I last saw the deceased alive on <u>11-14, 1956</u> , and that death occurred at <u>2:40 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W. Love MD</u>				23b. ADDRESS <u>Nevada, Mo</u>		23c. DATE SIGNED <u>11/16/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-17-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Newton Burial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Nevada Vernon Mo.</u>	
DATE REC'D BY LOCAL BFG. <u>11-17-1956</u>		REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wagon Funeral Service Inc</u>		ADDRESS <u>Nevada, Mo</u>	

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

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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 *H. H. Marmaduke*

Licensed Embalmer No. *2676*

P. O. Address *Nevada, N*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.