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diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

'57 022293  
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 181

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Farmington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Farmington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>701 Moore St.</b>		Length of stay in lb <b>1 Year</b>	d. STREET ADDRESS <b>701 Moore St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Leon</b> Last <b>Craig</b>			4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1911</b>	9. AGE (In years last birthday) <b>45</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>14</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lead Industry</b>		11. BIRTHPLACE (City and state or country) <b>St. Francois Co. Mo</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Robert Craig</b>		
14. MOTHER'S MAIDEN NAME <b>Kathryn Downey</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>498 05 0804</b>			17. INFORMANT <b>Bob Craig, Esther, Missouri</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Coronary Artery</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.)				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 <b>not attended</b> and last saw <sup>her</sup> him alive on <b>March 1957</b> Death occurred at <b>1:30 P. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>H. O. Gaele M.D.</b>			22b. ADDRESS <b>Desloge Mo</b>		22c. DATE SIGNED <b>6-8-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/10/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bonne Terre Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bonne Terre, Mo</b>
24. FUNERAL DIRECTOR <b>C. Z. BOYER &amp; SON</b>		ADDRESS <b>DESLOGE, MO.</b>		25. DATE REC'D. BY LOCAL REG. <b>June 8, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>

(Licensed Embalmer's Statement on Reverse Side)

JUN 20 1957  
JUN 21 1957

916

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 *J. T. Boyer*  
.....

Licensed Embalmer No. *36*

P. O. Address *Deering*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.