

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 29 1959

59-033704

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8663**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5560 Waterman Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM BYRON CRAIG			4. DATE OF DEATH Month Day Year September 18th. 1959		
5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-28-1888	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Dist. Assessor		10b. KIND OF BUSINESS OR INDUSTRY Assessor City	11. BIRTHPLACE (City and state or country) North Dakota	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME James Craig	13b. MOTHER'S MAIDEN NAME Omela Reith	14. NAME OF HUSBAND OR WIFE Marie Craig
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. 492-09-6231	17. INFORMANT Address Wm. Craig 124 W. Ceader

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) my 2761912 922115	
	DUE TO (c) 7440	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 a.m. p.m. Month, Day, Year	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 **124 1st St** to **2-18-1959** and last saw ~~him~~ ^{her} alive on **9-18-59**
Death occurred at **7:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James P. Sullivan MD (Degree or title)	22b. ADDRESS 2314 Taylor St 182 Longview	22c. DATE SIGNED 9-19-59
23a. BURIAL OR CREMATION, REMOVED (Specify) burial	23b. DATE 9-22-1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
		23d. LOCATION (City, town, or county) (State) St. Louis Missouri

24. FUNERAL DIRECTOR Arthur J. Donnelly ADDRESS 3840 LINDELL BLVD	25. DATE RECD. BY LOCAL REG. SEP 21 1959	26. REGISTRAR'S SIGNATURE Roan Smith. M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Ironia Williamson*

Licensed Embalmer No. 3565

P. O. Address 3840 Lind

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.