

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS FEB 24 1960

-60-007170

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 25 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>17 yrs</u>	c. CITY OR TOWN <u>Chillicothe</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>Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1015 Washington</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARSHALL</u> Middle <u>S.</u> Last <u>CRAIG</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>4,</u> Year <u>1960</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>4/20/82</u>	9. AGE (last birthday) <u>77/9/14</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Grundy Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John I. Craig</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Wilds</u>		14. NAME OF HUSBAND OR WIFE <u>Rose McCormick Craig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>493-38-9418</u>	17. INFORMANT Address <u>Mrs Rose Craig, Chillicothe, 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>Massive Gastrointestinal Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diverticulitis of colon</u> <u>UNKNOWN</u>
	DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Broncho pneumonia & Diabetes</u>		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 July 14, 1953 to Feb. 4, 1960 and last saw him live on Feb. 4, 1960
 Death occurred at 7:08 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William R. Farr, M.D.</u>	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>2/14/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Feb. 6, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sallem Cem.</u>	23d. LOCATION (City, town, or county) <u>Grundy Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>Gipson Funeral Home, Trenton, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2/23/60</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Kell</u>
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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

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Hal Johnson

Licensed Embalmer No. 340

P. O. Address Bx 95, Trenton

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