

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-011896

AMENDED ✓

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 880 STATE FILE NUMBER

**FILED APR 10 1961**

|   |                                  |   |                           |
|---|----------------------------------|---|---------------------------|
| 1. PLACE OF DEATH   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |                           |
| a. COUNTY   | ST. LOUIS                        | a. STATE  | MISSOURI COUNTY ST. LOUIS |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN   | JEFFERSON BARRACKS, MO.          | c. CITY OR TOWN   | KIRKWOOD ZONE 22          |
| Length of stay in 1b  |                                  | Inside Limits   |                           |
| 655 DAYS  |                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                   |                           |
| c. FULL NAME OF HOSPITAL OR INSTITUTION                             | VETERANS ADMINISTRATION HOSPITAL | d. STREET ADDRESS (If outside, give location)   | 44 HILL DRIVE             |
| Inside Limits   |                                  | Reside on Farm  |                           |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                   |                           |

|                                     |       |        |      |                  |       |     |      |
|-------------------------------------|-------|--------|------|------------------|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| CHARLES WALLACE CRAIG               |       |        |      | 3-30-61          |       |     |      |

|        |                  |  |                  |                        |                 |                |
|--------|------------------|--|------------------|------------------------|-----------------|----------------|
| 5. SEX | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HR |
| MALE   | WHITE            |  | 9-25-96          | 64                     | Months          | Days           |
|        |                  |  |                  |                        | Hours           | Min.           |

|   |                                   |  |                             |
|---|-----------------------------------|--|-----------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) | 12. CITIZEN OF WHAT COUNTRY |
| SALESMAN  | CELLOPHANE MATERIALS              | ST. LOUIS, MO.                             | USA                         |

|                     |                           |                             |
|---------------------|---------------------------|-----------------------------|
| 13a. FATHER'S NAME  | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
| ROBERT HOWARD CRAIG | ANN GWINN                 | -----                       |

|  |   |          |
|--|---|----------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 17. INFORMANT                               | Address  |
| YES WW-I   | Miss Nancy Craig, 44 Hill Dr. Kirkwood, Mo. | Daughter |

|   |   |
|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                             | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>  | 2 HOURS   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |   |
| DUE TO (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) | 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 |

|  |   |  |
|--|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 VA 5-14-59 to 3-30-61 and last seen with the deceased xxxxxxx

Death occurred at 6:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.

|                                  |                               |                  |
|----------------------------------|-------------------------------|------------------|
| 22a. SIGNATURE (Degree or title) | 22b. ADDRESS                  | 22c. DATE SIGNED |
| <i>Fred Ionata, M.D.</i>         | M.D. VA HOSP. JEFF. BRKS. MO. | 3-30-61          |

|   |           |                                    |   |
|---|-----------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| Removal                                   | 3/31/61   | Missouri Crematory                 | St Louis Missouri                             |

|                      |                        |                              |                            |
|----------------------|------------------------|------------------------------|----------------------------|
| 24. FUNERAL DIRECTOR | ADDRESS                | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE  |
| Edward Fendler       | 5611 South Grand Blvd. | 3-31-61                      | <i>John B. Murphy M.D.</i> |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

**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 Leo J. Budd

Licensed Embalmer No. 3989

P. O. Address St Louis Mo

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.