

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-014097

STATE FILE NUMBER

AMENDED **F**

Registration District No. **146**

Primary Registration District No. **3026**

Registrar's No. **195**

LED APR 19 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 74 yrs.	c. CITY OR TOWN Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 13003 E. 38th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MR. JAMES SHACKELFORD CRAIG			4. DATE OF DEATH Month Day Year April 8, 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1883	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Clerk-Emeritus		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Plattsburg, Mo.	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Joshua Craig		13b. MOTHER'S MAIDEN NAME Florence Shackelford		14. NAME OF HUSBAND OR WIFE Alba Craig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			17. INFORMANT Mrs. Alba Craig 13003 E. 38th, Indep., Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHATIC LEUKEMIA		INTERVAL BETWEEN ONSET AND DEATH
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 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 **11-21-58** to **DEATH** and last saw her/him alive on **4-7-61**
Death occurred at **2:15 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George Larson MD (Degree or title)	22b. ADDRESS 10901 WINNER RD.	22c. DATE SIGNED 4-10-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 11, 1961	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City, town, or county) (State) Independence, Missouri
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24. FUNERAL DIRECTOR OTT & MITCHELL, Indep., Mo.	25. DATE RECD. BY LOCAL REG. 4-11-61	26. REGISTRAR'S SIGNATURE James D. Craig, Deputy
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

APR 21 1961

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

Henry J. Mitchell

Licensed Embalmer No. 3925

P. O. Address 2nd St. N.W.

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.