

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018732

STATE FILE NUMBER

AMENDED

Street District No. 316 Primary Registration District No. 185 Registrar's No. 185

FILED MAY 16 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 49 Yrs. 3 Mos.		c. CITY OR TOWN St. James		Outside limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Unknown		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last CRAIG				4. DATE OF DEATH Month May Day 7 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1882,	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months 2 Days 21	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Common laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cuba, Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME William L. Craig			13b. MOTHER'S MAIDEN NAME Dora Fann			14. NAME OF HUSBAND OR WIFE Sarah Hayes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, State Hospital No. 4, Farmington, 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) Cerebral hemorrhage - - - - -							INTERVAL BETWEEN ONSET AND DEATH 6 das.
DUE TO (b) Cerebral arteriosclerosis - - - - -							Unknown.
DUE TO (c) _____							_____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Schizophrenia and diabetes mellitus.							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 March 19, 1959 to May 7, 1961 and last saw him alive on May 7, 1961 Death occurred at 1:35 A. M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>John A. Brennan M.D.</i>				22b. ADDRESS State Hospital No. 4 Farmington, Missouri		22c. DATE SIGNED 5-8-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 8, 1961	23c. NAME OF CEMETERY OR CREMATORY K.P. Cemetery		23d. LOCATION (City, town, or county) Farmington, Missouri		23e. (State)	
24. GENERAL DIRECTOR Miller Funeral Home, Farmington, Mo.				25. DATE RECD. BY LOCAL REG. May 8, 1961		26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>	

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 Paul H. DePaul

Licensed Embalmer No. 4120

P. O. Address Farmington

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.