

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-020368

STATE FILE NUMBER

AMENDED

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 28

FILED JUN 27 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Length of stay in 1b <u>25 YRS.</u>	c. CITY OR TOWN <u>Centralia</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>321 So. Allen St</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>321 So. Allen St.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>Perry</u> Last <u>Craghead</u>			4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1961</u>			
6. 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>Feb. 12, 1890</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (City and state or country) <u>Andrain Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>L. R. Craghead</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Cox</u>		14. NAME OF HUSBAND OR WIFE <u>Vannie Belle Craghead</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Vannie Belle Craghead</u>		

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) <u>Generalized debility</u>		<u>12 days</u>
DUE TO (b) <u>Cerebro-vascular accident</u>		<u>12 days</u>
DUE TO (c) <u>Generalized arteriosclerosis</u>		<u>11 years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dry gangrene of left lower leg-duration 10 weeks</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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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 February, 1952 to June 22, 1961 and last saw ^{her}him alive on June 22, 1961
 Death occurred at 1:05 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. Lachance, M.D. J. Lachance, M.D.</u>	22b. ADDRESS <u>110 W. Sneed, Centralia, Mo.</u>	22c. DATE SIGNED <u>June 23, 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 24-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Millersburg Cemetery</u>	23d. LOCATION (City, town, or county) <u>Millersburg, Missouri</u>
24. FUNERAL DIRECTOR <u>Pave O. Ballou, Centralia, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>June 23-1961</u>	26. REGISTRAR'S SIGNATURE <u>Maud M. Bride</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JUL 11 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 Paul J. Ballou

Licensed Embalmer No. 4206

P. O. Address Centralia, 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.