

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-000068

STATE FILE NUMBER

AMENDED

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 15

FILED JAN 30 1962

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| 1. PLACE OF DEATH a. COUNTY <u>Audrain</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u> | | Length of stay in 1b <u>7 days</u> | c. CITY OR TOWN <u>Upper Loutre Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS <u>Wellsville (If outside, give location) Star Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE GRETRUDE CRAIGHEAD</u> | 4. DATE OF DEATH Month Day Year <u>Jan. 17, 1962</u> |
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| 5. SEX <u>female</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>July 7, 1889</u> | 9. AGE (last birthday) <u>72</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u> | 11. BIRTHPLACE (City and state or country) <u>Callaway County, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> |
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| 13a. FATHER'S NAME <u>John D. Underwood</u> | 13b. MOTHER'S MAIDEN NAME <u>Susan Barker</u> | 14. NAME OF HUSBAND OR WIFE <u>Charles Craighead</u> |
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| 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>✓</u> | 17. INFORMANT Address <u>Nadine Letterman, Wellsville, Mo</u> |
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| 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>Thrombia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arteriolar nephrosclerosis</u> | | unknown |
| | DUE TO (c) | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rheumatoid arthritis</u> | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) |
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| 20c. TIME OF INJURY Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 |
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| 21. I attended the deceased from <u>July, 1956</u> to <u>Jan. 1962</u> and last saw her <u>9 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred on <u>Jan. 17, 1962</u> |
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| 22a. SIGNATURE (Degree or title) <u>Charles S. Gault MD</u> | 22b. ADDRESS <u>Mexico, Mo</u> | 22c. DATE SIGNED <u>1-18-62</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Jan. 19, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Wellville, Mo</u> | 23d. LOCATION (City, town, or county) (State) <u>Wellville Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Howard R. Myers, Wellsville, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Jan 19, 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u> |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 ITEM NO. 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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed L. Howard [Signature]

Licensed Embalmer No. 4494

P. O. Address Ellisville, 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.