S. No. 2
M—5-42
5-17-39
I X3267

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

7388

State File No.

FILED MAR 13 1943

Registration District No. 6297

Primary Registration District No. 6022

Registrar's No. 10

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Richmond, rural

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

South of Richmond /

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community All of life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray

(c) City or town Richmond, rural

(If outside city or town limits, write "RURAL")

(d) Street No. South of Richmond.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JAMES R. CRAVEN

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Linerva J. Craven

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased February 1, 1861 (Month) (Day) (Year)

8. AGE: Years 81 | Months 0 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Vibbard, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER

12. Name James Craven

13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name Margaret Clark

15. Birthplace Quincy, Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Roscoe Douglas

(b) Address Henrietta, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Orrick, Missouri

18. (a) Signature of funeral director

(b) Address Richmond, Missouri

19. (a) 3/5 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 23rd year 1943 hour 9:20 minute A. M.

21. I hereby certify that I attended the deceased from Jan 11 1943 to Feb 22 1943 that I last saw h alive on Feb 22 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
Due to	
Due to Arterio Sclerosis	
Other conditions (Include pregnancy within 3 months of death) Chronic Nephritis	

Major findings:

Of operations —

Of autopsy — 108

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed 3-25-43

1200

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3-12-43

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~~ .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed E. O. Thrasher

Licensed Embalmer No. 2073

P. O. Address Richmond, 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 this body is not embalmed, fact should be so stated above.

V. S. No. 2B
10M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7388

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 10

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James R. Craven
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. (Month) / (Day) 1862 (Year)

8. AGE: Years 81 | Months 0 | Days 22 | If less than one day: hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Feb 25 1943 (Date received local registrar) (b) (Mrs Chas W Shepard) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 23
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from ..... 19.....; that I last saw h... alive on ....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
(a) Lobar Pneumonia
Due to (b) arteriosclerosis
cerebral Hemorrhage
Due to (c)
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY