LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 27749

1 PLACE OF DEATH

County Monroe
Township Southfork
or
Village
or
City (NO. St.; Ward)

Registration District No. 586 File No. 11
Primary Registration District No. 5784 Registered No. 11

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rufus Creigh

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mall
4 COLOR OR RACE White
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH October (Month) 29 (Day) 1846 (Year)

7 AGE 76 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Va

PARENTS
10 NAME OF FATHER David S Creigh
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Va
12 MAIDEN NAME OF MOTHER Emley Arbuckle
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L A Creigh
(Address) Perry RR No 4

15 Filed Oct 9, 1923 Effie Drake Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 16 (Day) 1923 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 14, 1923, to Sept 16, 1923
that I last saw him alive on Sept 15, 1923
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Apoplexy
82A
97
(Duration) ....yrs. ....mos. 2½ ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) unknown yrs. ....mos. ....ds.
(Signed) John E Brown M. D.
Oct 1, 1923 (Address) Perry Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Southfork
DATE OF BURIAL Sep 17, 1923
20 UNDERTAKER Snyder & Hanger
ADDRESS Santa Fe Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs. ..... mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....,

that I last saw h.....alive on ....., 191.....

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
....., 191.....

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.