

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

Do not use this space.

MAR 24 1934

1. PLACE OF DEATH

County Randolph Registration District No. 735 File No. 6161
 Township _____ Primary Registration District No. 3034 Registered No. 91
 City Moberly (No. 410 So Clark) St. _____ Ward _____

2. FULL NAME

James M Creed
 (a) Residence, No. 410 So Clark St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grace Creed

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 17th 1884

7. AGE YEARS MONTHS DAYS If LESS than day, hrs. or min.
49 4 9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Painter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Self

10. Date deceased last worked at this occupation (month and year) Feb 26th 1934 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

13. NAME Capp Creed

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Georgia Edwards

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Harold Creed (ADDRESS) Moberly, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Moberly DATE Feb. 28th 1934

19. UNDERTAKER Mahan & Son (ADDRESS) Moberly, Mo

20. FILED 2/27 1934 Original Collier Registrar.

(3) MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 26th 1934

22. I HEREBY CERTIFY That I attended deceased from Feb 26, 1934, to Feb 26, 1934

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at 6:55 P

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset _____

106 W
180 W
100 W

100 W
100 W

Other contributory causes of importance:

Fracture Base of Cranium

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall from scaffold

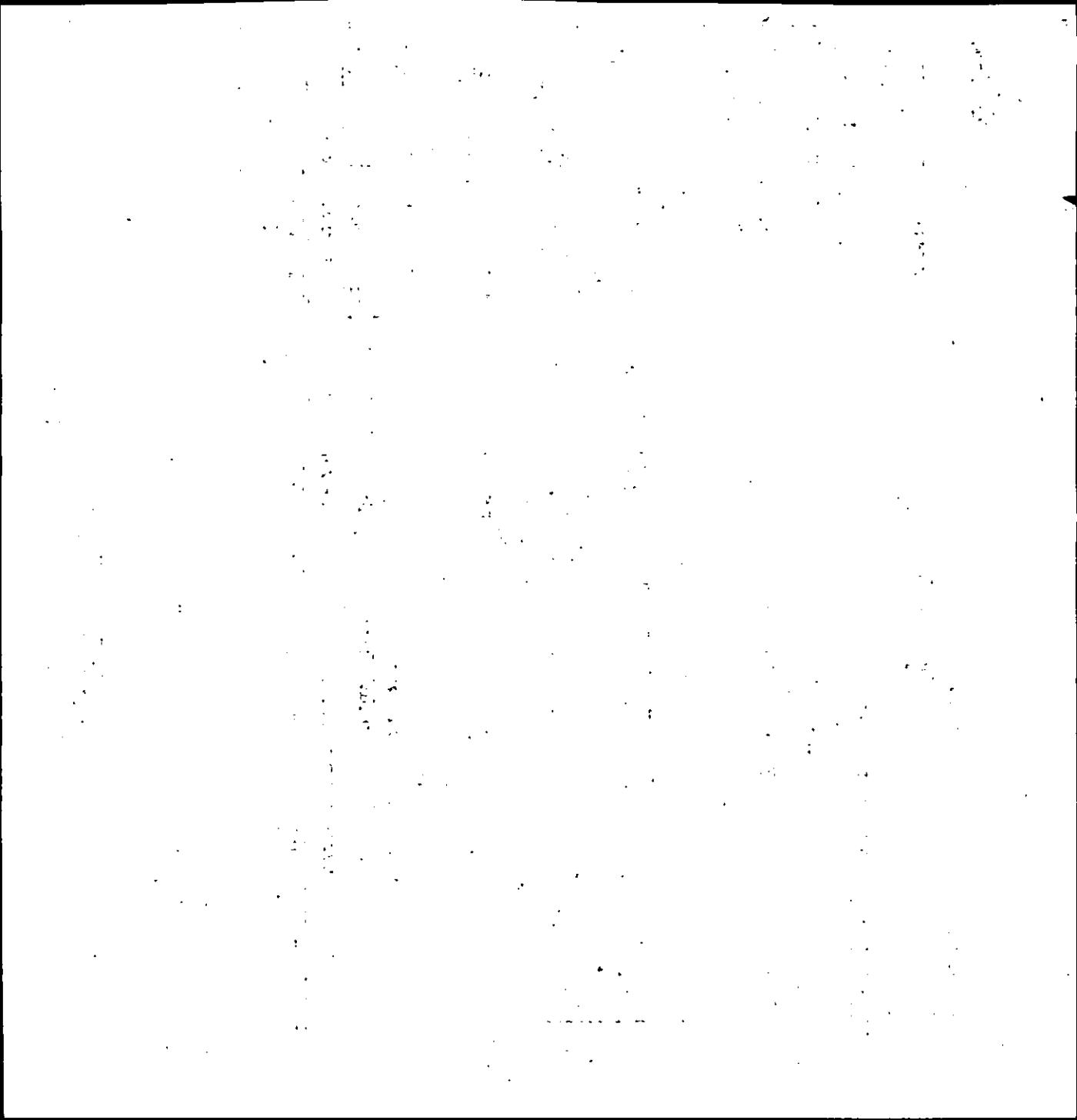
Nature of injury _____

24. Was disease of injury in any way related to occupation of deceased? Yes

If so, specify _____

(Signed) J. Nickel, M. D.

(Address) Moberly, Mo



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Randolph Registration District No. 735 File No. _____
 Township _____ Primary Registration District No. 3034 Registered No. 31
 City Moberly (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED _____ 19 Virginia Walker Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 26, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19 _____

I last saw him _____ alive on _____, 19 _____ Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Internal Hemorrhage Date of onset _____
Intercranial
 Other contributory causes of importance _____
Fracture of base of cranium
Accidentally fell from scaffold while at work

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1913-S