

K. 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**

41946
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Russ Primary Registration District No. 1002
 (c) City H.C. (d) Street No. 1600 E 8th St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **5012**

2. PRINT FULL NAME Susan C Creek

(a) Residence, No. 1600 E 8th St St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. A. Creek
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) aug 2, 1876
 7. AGE YEARS 62 MONTHS 4 DAYS 22 IF LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-24-31, 19
 22. I HEREBY CERTIFY, That I attended deceased from
 I last saw Deputy Coroner 19... Death is said to have occurred on the date stated above, at 8:10 p m.
 The principal cause of death and related causes of importance were as follows:
Chronic Debris Myocardium
Acute Pulmonary Edema
 Date of onset 6/10/31
 Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no
 FATHER 13. NAME unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 MOTHER 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 17. INFORMANT Mr. Betty L. Gatto (ADDRESS) H.C. Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Int Hope Church, 12-27-31
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. T. Gorman H.C. Mo.
 20. FILED Dec 25 1931 M. M. Brown Local Registrar.

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) Gunnerson M. D.
 (Address) H.C. Mo.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.