

OCT 19 1939

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

32370
Do not use this space.

1. PLACE OF DEATH

(a) County Casscade Registration District No. 302
(b) Township Clay Primary Registration District No. 6231
(c) City _____ (d) Street No. _____ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
620 Morrison Martin Creek

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 7 - 1939

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

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

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

FATHER 13. NAME Cecil Creek

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

MOTHER 15. MAIDEN NAME Anna Crider

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

17. INFORMANT (ADDRESS) Cecil Creek Blount Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Owensville DATE 9 - 8 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W.F. Gottenstruter Owensville Mo

20. FILED Sept 19 19 39 W. Bunge Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9 - 9, 19 39

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw h. _____ 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:

Stillborn - 9-7-39

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

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) Paul Brand, M. D. _____
Owensville, Mo

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.

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.

No Embalming

Signed *W.F. Gottenstrater*

Licensed Embalmer No. *1444*

P. O. Address *Owensville, 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, above space should be left blank.