DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 23 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7470

Registration District No. 587 | Primary Registration District No. 1595 | Registrar's No. 1

1. PLACE OF DEATH

(a) County: MONROE

(b) ~~City or town~~: RURAL – WOODLAWN (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: In this community: 39 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: MONROE

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

(d) Street No.: 6 MI. N OF MADISON, MO. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ... years

3. (a) PRINT FULL NAME: LAURA BELLE McCREERY

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife: THEODORE V. McCREERY

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

7. Birth date of deceased: JUNE (Month) 5 (Day) 1869 (Year)

8. AGE: Years 70 | Months 8 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace: MONROE CO., (City, town, or county) MO. (State or foreign country)

10. Usual occupation: AT HOME

11. Industry or business: ✓

FATHER
12. Name: JOHN FOREE
13. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: MALVINA JACKSON.
15. Birthplace: (City, town, or county) MO (State or foreign country)

16. (a) Informant's own signature: Pearl McCreery
(b) Address: MADISON, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: FEB. 12 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: OAK GROVE

18. (a) Signature of funeral director: Speed & Blakey
(b) Address: PARIS, MISSOURI

19. (a) 2-10-40 (Date received local registrar) (b) ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBY. day 10TH year 1940 hour 11 minute 25 A. M.

21. I hereby certify that I attended the deceased from Feb. 8, 1940, to Feb. 10, 1940; that I last saw her alive on Feb. 10, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Chr. myocarditis with acute myocardial failure — Duration: NK

Due to: —

Due to: —

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: None

Of autopsy: None

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: F. A. Barnetburg (M. D. or other)
Address: Date signed 2-10-40

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

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

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.

Rev. 5-17-39 1 X19211

RECEIVED
District Health Officer No. 10
District File Number 3-40-499
Date Filed MAR 20 1940

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 [illegible] Blakey

Licensed Embalmer No. 2614

P. O. Address Perth Amboy

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.

V. S. No. 2B
0M—2-21-40
I X22659

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. 7470

Registration District No. 587 Primary Registration District No. 5385 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Monroe

(b) City or town Woodlawn
(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 DEECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Laura Belle McCreery

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day hr. min.
70	8	5	

9. Birthplace (City, town, or county) (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) 2-10 1940 (Date received local registrar) (b) Fred W. Redding (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feby day 10 year 1940 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
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 F. A. Barnett (M. D. or other)

Address Paris Mo Date signed

2B
-40
22659

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. 7470

Registration District No. 587 Primary Registration District No. 1585 Registrar's No. 1

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Monroe

(b) City or town Woodland T. P.
(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
In this community years, months or days)

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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Laura Belle McCreery

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 5 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) Fred Wedding (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10
year 1940 hour minute M.

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

Immediate cause of death Chr Myo Carditis with acute Myo Cardial failure

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 F. A. Barnett (M. D. or other)
Address Paris Mo Date signed Feb 12-46