DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11644

Registration District No. 533 Primary Registration District No. 5713 Registrar's No. 30

1. PLACE OF DEATH:

(a) County MACON

(b) City or town Dudson - Rural (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 2 (Specify whether years, months or days)

In this community all her life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County MACON

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

(d) Street No. 1 mile north of town (If rural, give location)

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

3. (a) PRINT FULL NAME Drucella Creamer 656

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John O. Creamer 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Oct. (Month) 17th (Day) 1852 (Year)

8. AGE: Years 87 Months 4 Days 15 If less than one day ..... hr. ..... min.

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

10. Usual occupation House wife

11. Industry or business

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

MOTHER
14. Maiden name Mahalda Richardson
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mamie Bailey

(b) Address 3822 Flora Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 13-4-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Tabor Cemetery

18. (a) Signature of funeral director Stephens & Goodding

(b) Address Macon, Mo.

19. (a) 4/6/40 (Date received local registrar) (b) Leo Newton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3th year 1940 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb-16, 1939, to March-3-, 1940; that I last saw her alive on Mar-1-, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Degeneration with Arteriosclerosis	
Due to: General Arteriosclerosis	
Due to:	
Other conditions None (Include pregnancy within 3 months of death) 97	

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 A L Cambre (M. D. ~~or other~~)

Address Macon Mo Date signed 4-5-40

(Licensed Embalmer's Statement on Reverse Side)

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 I X19311

RECEIVED
District Health Officer No. 10
District File Number 4-40-761
Date Filed APR 9 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 C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11641

Registration District No. 535 — Primary Registration District No. 5713 — Registrar's No. 30

1. PLACE OF DEATH:
(a) County: MACON
(b) City or town: Rural (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: 2 (Specify whether
In this community: all his life (years, months or days) 1 57

2. (a) PRINT FULL NAME: Drucella Creamer

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Female

5. Color or race: W

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

6. (b) Name of husband or wife: John O. Creamer

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

7. Birth date of deceased: Oct. (Month) 17th (Day) 1852 (Year)

8. AGE: Years 87 Months 4 Days 15 If less than one day hr. min.

9. Birthplace: Macon Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: House wife

11. Industry or business:

MOTHER FATHER

12. Name: ~~Efferiam May~~ Ephraim May

13. Birthplace: Virginia (City, town, or county) (State or foreign country)

14. Maiden name: ~~Melissa Pickerson~~ Tolitha

15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mamie Bailey

(b) Address: 3822 Flora Kansas City, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-8-1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Tabor Cemetery

18. (a) Signature of funeral director: Stephens & Goodsley

(b) Address: Macon, Mo.

19. (a) 3-16-40 (Date received local registrar) (b) [illegible] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: MACON
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: 1 mile north of town (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd year 1940 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb-11 1939 to March-3 1940 that I last saw he alive on Mar-3 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage with Arteriosclerosis — Duration

Due to: General Arteriosclerosis

Due to:

Other conditions: None (Include pregnancy within 3 months of death) 47

Major findings: Of operation: 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? (c) Means of injury:

23. Signature: A. L. Crawford (M. D.)
Address: Macon Mo. Date signed: 4-5-40

CAUSE OF DEATH is plain terms, so that it may be understood by a layman. Use no abbreviations or terms not in common use. Example: Not "Ca. Ut." but "Cancer of Uterus." Not "Cerebral Hemorrhage" but "Cerebral Hemorrhage, Ruptured Blood Vessel." Not "Cardiac Failure" but "Cardiac Failure, Heart Disease." Not "Senile" but "Senile Decay." Not "Pneumonia" but "Pneumonia, Lobar." Not "Tuberculosis" but "Tuberculosis, Pulmonary." Not "Cancer" but "Cancer, Stomach." Not "Nephritis" but "Nephritis, Chronic Interstitial." Not "Uremia" but "Uremia, Cause Unknown." Not "Pyelitis" but "Pyelitis, Chronic Interstitial." Not "Cystitis" but "Cystitis, Chronic." Not "Pyelitis" but "Pyelitis, Chronic Interstitial." Not "Cystitis" but "Cystitis, Chronic." Not "Pyelitis" but "Pyelitis, Chronic Interstitial." Not "Cystitis" but "Cystitis, Chronic."

(Licensed Embalmer's Statement on Reverse Side)