

FILED JAN 13 1945

Registration District No. **132**

Primary Registration District No. **3027**

Registrar's No. **334**

1. PLACE OF DEATH:

(a) County **Grundy**
(b) City or town **Trenton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Wrights Memorial Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Daviess**
(c) City or town **"Rural" Union Township**
(If outside city or town limits, write "RURAL")
(d) Street No. **1 1/2 Mi. South Gallatin, Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Lily May Place**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **Wm. Creekmore** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **January 7 1868**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 10 22 hr. min.

9. Birthplace **Daviess County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

MOTHER FATHER { 12. Name **John McCrary**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Rhoda Edwards**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Fred Whitt**
(b) Address **Gallatin, Missouri**

17. (a) **Burial** (b) Date thereof **11-30-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **McCrary Cemetery**

18. (a) Signature of funeral director **Hone Funeral Home**

(b) Address **Gallatin, Missouri**

19. (a) **12-1-44** (b) **L. J. Roberts**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November**, 29
year **1944** hour **3:30** minute **30** M.

21. I hereby certify that I attended the deceased from **Oct 1st**
1944 to **Nov. 29th**, 1944
that I last saw her alive on **Nov. 29th**, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis 2 years**

Due to **Do not know**

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **g3h**
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?

While at work (Specify type of place) Means of injury **D**

23. Signature **Oliver F. Duff** (M. D. or other) **M. D.**
Address **Trenton Mo** Date signed **30 Dec 1944**

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

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

L. O. Richesson
Licensed Embalmer No. 3307

P. O. Address Fall River, Mass.

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, fact should be so stated above.