

FILED JAN 14 1946

Registration District No. 99

Primary Registration District No. 5380

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Da. Kawe South Washington  
(b) City or town Maysville (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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 2 YEARS  
years, months or days

3. (a) PRINT FULL NAME BEATY B. GREAMER

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: OCTOBER 22 1870  
(Month) (Day) (Year)

8. AGE: Years 15 Months \_\_\_\_\_ Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation LABOR

11. Industry or business \_\_\_\_\_

12. Name George A. Greamer

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

14. Maiden name Lucy R. Morgan

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

16. (a) Informant MR. EARL JOHNSON

(b) Address OSBORN, Mo.

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OSBORN, Mo.

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11-25-45 (b) Roscoe Davidson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DE Kalb 32  
(c) City or town Maysville RURAL  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10  
year 1945 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept.  
1, 1945 to Nov 10, 1945

that I last saw him alive on Nov 3, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Coronary Thrombosis

Due to Arteriosclerosis

Due to Hypertension & similar

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 940

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 Roscoe Davidson M. D. or other \_\_\_\_\_

Address Stewartville Mo Date signed 11-19-45

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

DISTRICT HEALTH OFFICE  
Cameron, 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 J. L. Byrd

Licensed Embalmer No. 952

P. O. Address Stewartville, 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, fact should be so stated above.**

Registration District No. 29 Primary Registration District No. 5380

1. PLACE OF DEATH:

(a) County DeKalb  
(b) City or town Rural Washington  
(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)

3. (a) PRINT FULL NAME Beaty B Creamer

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 22 1945  
(Month) (Day) (Year)

8. AGE: Years 15 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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 (Burial, cremation, or removal) (b) Date thereof Nov 25-45 (Month) (Day) (Year)

(c) Place: burial or cremation Ozborn, Mo.

18. (a) Signature of funeral director F. J. Lyon  
(b) Address Stewartville, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

41058