

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11134

State File No.

BIRTH NO. _____ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Saline</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> | |
| b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Slater, Mo.</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u> | |
| c. LENGTH OF STAY (in this place) <u>2 yrs</u> | | d. STREET ADDRESS (If rural, give location) <u>218 E. Maple</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>218 E. Maple</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Lewis Thomas</u> b. (Middle) <u>Creed</u> c. (Last) <u>Creed</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 20 1949</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Jan 28, 1860</u> |
| 9. AGE (In years last birthday) <u>89</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u> | IF UNDER 48 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> |
| | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>James M. Creed</u> | | 13b. MOTHER'S MAIDEN NAME <u>Melvina Mildred Hill</u> | 14. NAME OF HUSBAND OR WIFE <u>Laura Etta Creed</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u> | | 16. SOCIAL SECURITY NO. <u>no.</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Eva Brandenburg Slater, Mo.</u> |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Nephritis</u> ANTECEDENT CAUSES DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Chronic Cystitis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>5/12</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Slater Saline Mo.</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>Mar. 15</u> , 19 <u>49</u> , to <u>Mar. 20</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Mar. 19</u> , 19 <u>49</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>O. C. McBurney M.D.</u> | | 23b. ADDRESS <u>Slater, Mo.</u> | 23c. DATE SIGNED <u>3/20/49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Mar. 22, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>RFD, Cairo, Mo., Rand. Mo.</u> |
| DATE REC'D BY LOCAL REG. <u>3-23-49</u> | REGISTRAR'S SIGNATURE <u>Mrs. Earl C. Metz</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Swout Funeral Home Mahesh, Mo.</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. _____

District File Number _____

Date Filed 3-28-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Charles L. Shelton

Signed _____
Student Embalmer

Licensed Embalmer No. #4577

P. O. Address Moberly, 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.