

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19487**

FILED JUL 2 - 1951

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **661**

0117
2

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

1. PLACE OF DEATH a. COUNTY Duchesne		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph, Mo		c. CITY (If outside corporate limits, write RURAL and give township) By the date, Missouri	
c. LENGTH OF STAY (in this place) 10 mos		d. STREET ADDRESS (If rural, give location) 0410	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital # 2			

3. NAME OF DECEASED (Type or Print)	a. (First) Samuel	b. (Middle) T.	c. (Last) Kreamer	4. DATE OF DEATH (Month) (Day) (Year) June 20, 1951
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 18, 1876	9. AGE (In years last birthday) 74	if UNDER 1 YEAR 9 Months 9 Days	if UNDER 2 HRS. 2 Hours 2 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) By the date, Harrison County Mo. USA	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Blanche Kreamer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Blanche Kreamer & Hospital Record	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) chronic myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerosis DUE TO (c) Senile Psychosis 4221		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 1, 1951**, to **June 20, 1951**, that I last saw the deceased alive on **June 19, 1951**, and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Forrest Thomas MD	23b. ADDRESS St. Joseph, Mo. State Hospital	23c. DATE SIGNED 6/20-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-20-51	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Engleville Mo.
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DATE REC'D BY LOCAL REG. June 23, 1951	REGISTRAR'S SIGNATURE Carl C. Casty	446	25. FUNERAL DIRECTOR'S SIGNATURE Earl Clark	ADDRESS 120 Illinois Ave.
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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..... *Earl A. Clark*

Signed.....
Student Embalmer

Licensed Embalmer No. *4238*

P. O. Address. *St. Joseph 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.