

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40495

State File No.

BIRTH NO. _____ REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 5368 Registrar's No. 9

| | | | |
|---|--|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Daviess</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u> | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Coffey, Mo.</u> | | c. LENGTH OF STAY (in this place) <u>83 Yrs</u> | c. CITY OR TOWN <u>Coffey, Mo.</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | e. STREET ADDRESS (If rural, give location) <u>0310</u> | |

| | | | |
|---|-----------------------|----------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Ella</u> | b. (Middle) <u>G.</u> | c. (Last) <u>Creighton</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 19, 1954</u> |
|---|-----------------------|----------------------------|--|

| | | | | | | | | |
|--|-------------------------------|---|---------------------------------------|---|------------------------|--|-----------------------|-----------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>June 13, 1871</u> | 9. AGE (In years last birthday) <u>83</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 1 HRS. Hours | IF UNDER 15 MIN. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Coffey, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |

| | | |
|--|--|--|
| 13a. FATHER'S NAME <u>Squire Galbreath</u> | 13b. MOTHER'S MAIDEN NAME <u>Martha Jane Brown</u> | 14. NAME OF HUSBAND OR WIFE <u>Harrison S. Creighton</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>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Harrison S. Creighton, Coffey, Mo.</u> | ADDRESS |
|--|-------------------------------------|---|---------|

| | | | |
|---|--|--|--|
| 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 | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> | | |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) | | |
| 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 | 20. AUTOPSY? <u>194 X</u> YES <input type="checkbox"/> NO <input 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) |
|--|--|---|

| | | |
|---|--|----------------------------|
| 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 Nov 18 to Nov 19, 1954, that I last saw the deceased alive on Nov 18, 1954, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

| | | |
|---|----------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>J. B. Enshaw M.D.</u> | 23b. ADDRESS <u>Jamestown Mo</u> | 23c. DATE SIGNED <u>12/6/54</u> |
|---|----------------------------------|---------------------------------|

| | | | |
|---|-----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>11-21-1954</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Coffey Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Coffey, Mo.</u> |
|---|-----------------------------|---|--|

| | | | | |
|--|--|------|---|--------------------------------|
| DATE REC'D BY LOCAL REG. <u>12-16-54</u> | REGISTRAR'S SIGNATURE <u>Virginia M. Engelhart</u> | 81-0 | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. ...</u> | ADDRESS <u>Pattonburg, Mo.</u> |
|--|--|------|---|--------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

310

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..

Student.....
Signature of Student Embalmer

Signed *Louis Quest*.....

Licensed Embalmer No. *4091*

P. O. Address *Patterson, Ca*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.