

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010825

STATE FILE NUMBER

2 No 3053

Health, Welfare
Public Service

300
-57

91
0

Registration District No. _____ Primary Registration District No. _____ Registrant No. **3053**

FILED APR 10 1959

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY _____

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Inside Limits Yes No

c. CITY OR TOWN **St. Louis** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Missouri Baptist** Length of stay in lb _____

d. STREET ADDRESS **1633 a Knapp** (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **George** Middle **Michael** Last **Creed**

4. DATE OF DEATH Month **Mar** Day **25** Year **1959**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH **Sep 12 1879** 9. AGE (In years last birthday) **79** IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Roofer & Tuckpointer** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) **Lebanon Ill** 12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Charles Creed** 13b. MOTHER'S MAIDEN NAME **Mary Campbell** 14. NAME OF HUSBAND OR WIFE **Margaret Ryan Creed**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **—** 17. INFORMANT **Margaret Creed** Address **1633 a Knapp**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Respiratory Obstruction (Trachea). Carcinoma (Anaplastic) Throat 6 mo. outlet & base of neck.**
DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **164X**

INTERVAL BETWEEN ONSET AND DEATH _____

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from **Jan 59** to **March 24** and last saw him alive on **3/24/59**. Death occurred at **12:00 PM 3/25/59** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **W. L. Lerner** (Deceased or title) 22b. ADDRESS **45-301 Taylor Ave** 22c. DATE SIGNED **3/25/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **Mar 27 59** 23c. NAME OF CEMETERY OR CREMATORY **Calvary** 23d. LOCATION (City, town, or county) **St. Louis Mo** (State) _____

24. FUNERAL DIRECTOR **E.J. Schnur** ADDRESS **3125 Lafayette** 25. DATE RECD. BY LOCAL REG. **MAR 26 '59** 26. REGISTRAR'S SIGNATURE **Earl Smith, M.D.**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Thomas R. Denwick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.