

DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-024701

FILED VS JUL 20 1959

Registration District No. 118 Primary Registration District No. 4188 Registrar's No. 20

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Owensville</u>		Length of stay in 1b <u>30 yrs.</u>		c. CITY OR TOWN <u>Owensville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>411 Apple</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSA ANNA CREEK</u>				4. DATE OF DEATH Month Day Year <u>July 10, 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>St. James, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jack Hayes</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Shanks</u>		14. NAME OF HUSBAND OR WIFE <u>William Creek</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 Address <u>Mo.</u> <u>Mrs. Dorothy Ringelsen Owensville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degeneration</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Glaucome. Arthritis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		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.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>1-24-58</u> to <u>7-10-59</u> and last saw <u>her</u> alive on <u>7-9-59</u> Death occurred at <u>11:50</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Paula Brenner, M.D.</u> (Degree or title)				22b. ADDRESS <u>Owensville, Mo.</u>		22c. DATE SIGNED <u>7-11-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>7-12-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>near Owensville, Mo.</u>	
24. FUNERAL DIRECTOR <u>Gottenstroeter F. Home Owensville,</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>July 11, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Mieford Winter, Dep.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 38

P. O. Address OWENSON

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.