

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

=60-026420

STATE FILE NUMBER

Registration District No. 111 Primary Registration District No. 5427 Registrar's No. 23

| | | | | | | | | | |
|---|--|---|--|---|---|--|--|----------------------------------|------|
| 1. PLACE OF DEATH a. COUNTY Franklin | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Seward | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Calvey Twp. | | Length of stay in 1b 2 mos. | | c. CITY OR TOWN Liberal | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt. #0 | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Emma Middle Mary Last Creason | | | | 4. DATE OF DEATH Month Aug. Day 3, Year 1960 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 21, 1878 | 9. AGE (last birthday) 82 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME William Kramme | | | 13b. MOTHER'S MAIDEN NAME Emily Strieback | | | 14. NAME OF HUSBAND OR WIFE Jos. Creason | | | |
| 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 Address Joseph Creason Liberal, Kansas | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Presumed Coronary Arteriosclerosis</i> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <i>Cardiovascular disease - Non-Tumor</i> | | | | | | | |
| | | DUE TO (c) <i>Coronary Thrombosis</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Widow prior to arrival of physician</i> | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 _____, to _____, and last saw her/him alive on _____. Death occurred at <u>1:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Dr. Robert M. Larson</i> | | | | 22b. ADDRESS <i>Union Ind State</i> | | | | 22c. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug. 6, 1960 | 23c. NAME OF CEMETERY OR CREMATORY St. Martins Cemetery | | 23d. LOCATION (City, town, or county) Dittmer, Mo. | | (State) | | |
| 24. FUNERAL DIRECTOR Casey-Lenox | | | ADDRESS St. Clair, Mo. | | 25. DATE RECD. BY LOCAL REG. Aug. 5-1960 | | 26. REGISTRAR'S SIGNATURE <i>Mary B. Green</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 K. M. Fenwick, Jr.

Licensed Embalmer No. 5090

P. O. Address St. Clair,

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.