

AUG 10 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

25563

Do not use this space.

## 1. PLACE OF DEATH

(a) County Franklin Registration District No. 574  
(b) Township Central Primary Registration District No. 5407B Registered No. \_\_\_\_\_  
(c) City Morrellton (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Albert Creason

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Katherine Creason</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept. 3, 1863</u>		
7. AGE YEARS <u>75</u>	MONTHS <u>10</u>	DAYS <u>16</u>
IF LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. _____		
10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) <u>Kokomo,</u> (STATE OR COUNTRY) <u>Indiana.</u>		
13. NAME <u>George Creason</u>		
14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Indiana</u>		
15. MAIDEN NAME <u>Emma Ann Davis</u>		
16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Indiana.</u>		
17. INFORMANT <u>Katherine Creason</u> (ADDRESS) <u>Morrellton Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Fairview Cem.</u> DATE <u>July 22,</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) <u>Casey &amp; Lenox</u> (ADDRESS) <u>St. Clair, Mo.</u>		
20. FILED <u>8/9</u> 19 <u>39</u> <u>Morrellton</u> Local Registrar.		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 15 - 30, July 20, 1939

I last saw him alive on July 20, 1939 Death is said to have occurred on the date stated above, at 8:30 a. m.  
The principal cause of death and related causes of importance were as follows:

Tumor of Brain Date of onset ?

Other contributory causes of importance:  
Uremia 4/8/39

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis Uremia Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify W. E. Cleason, M. D.  
(Signed) W. E. Cleason  
Address St. Clair

55/10

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *B. M. Lenz*

Licensed Embalmer No. 3601

P. O. Address St. Clair, 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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

25563  
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 294  
 (b) Township Central Primary Registration District No. 5409B Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Albert Creason

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-20-1937

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
75 10 16

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

Tumor of Brain Date of onset \_\_\_\_\_  
Benign  
 Other contributory causes of importance: Worms 54

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_\_\_

Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) W. E. Mitchell, M. D.

(Address) St. Louis

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAWS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-25563 1939