

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

SEP 6 1939

28067

Do not use this space.

1. PLACE OF DEATH

(a) County..... Jackson..... 1 Registration District No..... 399
 (b) Township..... Kaw..... 2 Primary Registration District No..... 1002
 (c) City..... Kansas City, Mo..... (d) Street No..... St. Joseph Hospital, K.C. Mo..... 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

(a) Residence, No. Overland Park, Kansas. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9th, 1916

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
 23 3 22

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. Iron Worker
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Kansas City, (STATE OR COUNTRY) Kansas.

13. NAME William C. Creek,

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

15. MAIDEN NAME Ida Hastings

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

17. INFORMANT Mrs. William S. Creek, (ADDRESS) Lenexa, Kansas.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lenexa, Kansas. DATE Aug. 3rd, 1939

19. FUNERAL DIRECTOR (NAME) Mrs. C. L. Forster (ADDRESS) 918 Brooklyn Avenue, K.C. Mo.

20. FILED Aug 1, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-1-39 19

22. I HEREBY CERTIFY That I attended deceased from 19... to 19... 19... 19...

I last saw deceased on 5th 19... Death is said to have occurred on the date stated above, at 5²⁵ p.m.

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

Rubeola, Trauma
 Fracture of the Skull
 Congenital Bicuspid Aortic Valve

Other contributory causes of importance:
 208-70

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 7-13-39

Where did injury occur? Jackson, Mo. (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... Fracture of Skull

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

If so, specify

(Signed) Russell J. ... M. D.

(Address) ...

N. B.—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.

JAN 27 1945

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

Charles H. Wise

Licensed Embalmer No. *2570*

P. O. Address *918 Broadway*

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.