

Registration District No. **160**

Primary Registration District No. **4084**

Registrar's No. **7**

1. PLACE OF DEATH:
(a) County **Cass**
(b) City or town **Creighton Mo**
(c) Name of hospital or institution **W**
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution **60 yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John G Page 200**
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ethel Page** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 21** (Month) (Day) (Year)

8. AGE: Years **60** Months **3** Days **17** If less than one day hr. min.

9. Birthplace **Creighton Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Robert Page**

13. Birthplace **Unknown** (City, town, or county) (State or foreign country)

14. Maiden name **Ann Marie Godwin**

15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Ethel Page**

(b) Address **Creighton Mo**

17. (a) **Grant Cem** (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation **Grant Cemetery**

18. (a) Signature of funeral director **Fred Wilkerson**

(b) Address **Clinton Mo**

19. (a) **Nov 9 1939** (b) **Ans. W. L. Jennings** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Cass**
(c) City or town **Creighton** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **8** year **1939** hour **2** minute **25 PM**

21. I hereby certify that I attended the deceased from **Jan 1 - 31** 19**39** to **Nov 8** 19**39**
that I last saw him alive on **Nov 8** 19**39** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
2 1/2
2 1/2 Duration

Due to _____
Due to **121**

Other conditions **Coronary Arteriosclerosis** (Include pregnancy within 3 months of death) **3 1/2**

Major findings: Of operations **None**

Of autopsy **None**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **2 30**

(b) Date of occurrence **Nov 8**

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? **Yes** (Specify type of place) (e) Means of injury **Yes**

23. Signature **Fred Wilkerson** (M. D. or other) **1**
Address **Clinton City Mo** Date signed **Nov 9 1939**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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 Fred Welkerson

Licensed Embalmer No. 2478

P. O. Address Clinton, 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

39267

Do not use this space.

1. PLACE OF DEATH

(a) County Cass Registration District No. 150
(b) Township _____ Primary Registration District No. 4084 Registered No. _____
(c) City Creighton (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

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 21, 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 3 17

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

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

MOTHER 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 Nov 10 1919 Mrs W L Cummings Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19____

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the _____ stated above, at _____ m.

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

Date of onset

Other contributory causes of importance:

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) _____, M. D.

(Address) _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

