

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home Station 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME William Clinton Creshaw  
8. (b) If veteran, name war No  
8. (c) Social Security No. No

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Bessie Creshaw  
6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased 1 1871  
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 25  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace unknown  
(City, town, or county) (State or foreign country)

10. Usual occupation mail handler

11. Industry or business H. C. Terminal R. R.

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant's own signature J. H. Creshaw

(b) Address 2915 W. Marshall

17. (a) Home City / Kansas (b) Date thereof 12-29-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation not kept

18. (a) Signature of funeral director George H. Malloy  
(b) Address 1111 State St. H. C. Terminal

19. (a) Dec 27, 1939 (b) unknown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 29337 Anthony  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 26  
year 1939 hour 8:00 P.M. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Gravid metrorrhoidal crisis (post)

Due to Chronic Unifocal (R)

Due to Coronary Arteriosclerosis

Other conditions 82 1/2  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy section

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(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? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature J. H. Creshaw (M. D. or other) \_\_\_\_\_

Address Creshaw Date signed 12/29/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**