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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 3 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Tuesday

State File No. 10045

Registration District No. 72 Primary Registration District No. 5037 Registrar's No. 1

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

04
0
0

1. PLACE OF DEATH:
(a) County Gentry
(b) City or town Wilson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 65 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 004
(a) State (b) County 0
(c) City or town 0
(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.? 0 years.

3. (a) PRINT FULL NAME WILLIAM NEWTON CREASEY
3. (b) If veteran, name war No
3. (c) Social Security No. No.
4. Sex MO
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 4 (Month) 25 (Day) 1862 (Year)

8. AGE: Years	Months	Days	If less than one day
79	11	2	hr. min.

9. Birthplace Gentry Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER
12. Name Robert Creasey
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Susan Long
15. Birthplace Howard Co (City, town, or county) Mo. (State or foreign country)
16. (a) Informant G. W. Creasey
(b) Address Centralia Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (Month) 27 (Day) 42 (Year)
(c) Place: burial or cremation Liberty Church Cemetery
18. (a) Signature of funeral director [illegible]
(b) Address Centralia Mo
19. (a) 3/26-1942 (Date received local registrar) (b) Mrs. Arch. Playter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 25
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 3/3/42, 19, to 3/25/42, 19;
that I last saw him alive on 3/25/42, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to	
Due to 93d	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other)
Address Centralia Mo Date signed 3/25/42

(Licensed Embalmer's Statement on Reverse Side)

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 M J McDonald

Licensed Embalmer No. 2589

P. O. Address Centralia 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, fact should be so stated above.

. S. No. 2B
0M—8-21-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10045

Registration District No. 72 Primary Registration District No. 5037 Registrar's No.

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Audrain
(c) City or town Rural - Thompson
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William N. Creasey
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Apr. (Month) 25 (Day) 1862 (Year)
8. AGE: Years 79 Months 11 Days 2 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 3-28-42 (Date received local registrar) (b) Mrs. Arch Playter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. Day 25 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY