

**FILED JUN 13 1946**

Registration District No. 72

Primary Registration District No. 5289

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Rural Gallatin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Oakwood Addition North Kansas City  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution XXXX (Specify whether)  
In this community 53 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay  
(c) City or town None  
(If outside city or town limits, write "RURAL")  
Street No. Oakwood Add. North Kansas City  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country XXXXX

3. (a) PRINT

FULL NAME Reed E. Creason

3. (b) If veteran, name war NO  
3. (c) Social Security No. 490-30-636

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louedia Creason  
6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Aug. 20 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
53 9 16 XX hr XX min.

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

10. Usual occupation Paving Contractor

11. Industry or business Self

12. Name Willis Creason

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

14. Maiden name Lawson

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

16. (a) Informant Mrs. Louedia Creason

(b) Address Oakwood Add. North Kansas City

17. (a) BURIAL (b) Date thereof May 8 - 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Karney Mo.

18. (a) Signature of funeral director Walter Smith

(b) Address North Kansas City

19. (a) May 8 - 1946 (b) Buelah Kitchener  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6  
year 1946 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from May 6  
1946 to May 6 1946  
that I last saw him alive on May 6 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Duration 10 hr  
Due to Coronary Artery disease  
Brain & "overstrain" 24 hr.

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.

SUPPLEMENTARY INFORMATION REQUESTED

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) (e) Means of injury

23. Signature William King (M. D. or other)

Address 1000 ... Date signed 5-8-46

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6-12-46

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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 \_\_\_\_\_

*Theron O. Smith*

Licensed Embalmer No. 3928

P. O. Address North Kansas City

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

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1. PLACE OF DEATH:

(a) County Clay  
(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

In this community  
years, months or days)

3. (a) PRINT FULL NAME Reed E. Creason

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 m

6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive: \_\_\_\_\_

7. Birth date of deceased: aug 20 (Month) (Day) (Year)

8. AGE: 53 Years 9 Months 20 Days (if less than one day) hr. \_\_\_\_\_ min.

9. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation: \_\_\_\_\_

11. Industry or business: \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation: \_\_\_\_\_

18. (a) Signature of funeral director: \_\_\_\_\_

(b) Address: \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: \_\_\_\_\_ (b) County: \_\_\_\_\_

(c) City or town: \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No.: \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death: \_\_\_\_\_

Duration

Due to: Bunch of pneumonia

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: 107

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury: \_\_\_\_\_

23. Signature: Wm Penghus (M. D. or other) \_\_\_\_\_

Address: \_\_\_\_\_ Date signed: 6/17/46

SUPPLEMENTARY

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

44962

16070