No. 2
-12-45
5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 4 1947

Registration District No. 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34426

Primary Registration District No. 1002

Registrar's No. 4455

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Kansas (b) County: Smith 999

(c) City or town: Smith Center 14
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Duane Creamer

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

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:

7. Birth date of deceased: Dec (Month) 18 (Day) 1930 (Year)

8. AGE: Years 16 Months 10 Days 6 If less than one day hr. min.

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

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: Cecil Creamer
13. Birthplace: Kansas (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Susie Way
15. Birthplace: Kansas (City, town, or county) (State or foreign country)

16. (a) Informant: Cecil Creamer
(b) Address: Smith Center, Ks.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof: 10-27-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Smith Center, Ks.

18. (a) Signature of funeral director: Pa Fulton
(b) Address: Kansas City, Kansas

19. (a) 10-25-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24 year 1947 hour 4 minute — A.M.

21. I hereby certify that I attended the deceased from Oct. 21, 1947, to Oct. 24, 1947 that I last saw him alive on Oct 23, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Edema of Brain	72 hrs +
Due to Encephalomalacia, Left Temporal Lobe	2 wks ?
Due to Basilar adhesions	
Other conditions (Include pregnancy within 3 months of death) 83C	

Major findings:
Of operations: Edema of Brain

Of autopsy: as above. Microscopic studies not available

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: 0

23. Signature: Donald F. Coburn (M. D. or other) MD

Address: 110 3 Grand KCMo Date signed Oct 24/47

(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. M. Swisher

Licensed Embalmer No. 3505

P. O. Address Kerrville

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.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4455

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hosp.
(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)

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

3. (a) PRINT FULL NAME Duane Creamer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months 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

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) 10-25-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24
year 1947 hour 4 minute a M.

21. I hereby certify that I attended the deceased from Oct. 21, 1947, to 10-24, 1947;
that I last saw him alive on 10-23, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: edema of brain	72 hrs. t.
Due to encephalomalacia left temporal lobe	2 wks. ?
Due to basilar adhesions hemorrhagic encephalitis	
Other conditions virus in origin (Include pregnancy within 3 months of death)	

Major findings:
Of operations edema of brain
Of autopsy as above. 83C

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 Donald P. Coburn (M. D. or other)
Address 1103 Grand Date signed 10-24-47

5-34426