No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19034

BIRTH NO. ____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 5352 Registrar's No. 50

1. PLACE OF DEATH
a. COUNTY: Dallas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Plad "Rural" 1
c. LENGTH OF STAY (In this place): 5yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missorui
b. COUNTY: Dallas 30
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Plad "Rural" 0
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Van
b. (Middle): Doley
c. (Last): Creach

4. DATE OF DEATH (Month) (Day) (Year): June 7, 1949

5. SEX: male 0

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Mar. 22, 1875

9. AGE (In years last birthday): 74
If under 1 year: Months 2 Days 15
If under 24 hrs.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): 9

12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6-1-49

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — 4201

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-1, 1949, *to* 6-7, 1949, *that I last saw the deceased alive on* 6-6, 1949, *and that death occurred at* 8 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Claude O. Hammon (Degree or title): M.D.

23b. ADDRESS: Buffalo Mo.

23c. DATE SIGNED: 6-14-49

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 6-11-49

24c. NAME OF CEMETERY OR CREMATORY: Manley Cemeteery

24d. LOCATION (City, town, or county) (State): Battlefield, Missouri

DATE REC'D BY LOCAL REG.: 6/18/49

REGISTRAR'S SIGNATURE: Mrs J. B. Jones 80

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: L. B. Jones Buffalo, Missouri

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 549-
Date Filed 6-30-

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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Signed Morris B. Jones

Signed _____
Student Embalmer

Licensed Embalmer No. 4329

P. O. Address Buffalo, 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.