ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-014792
STATE FILE NUMBER

AMENDED

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 57

FILED APR 18 1961

1. PLACE OF DEATH
a. COUNTY: RAY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: RICHMOND TWSP
Length of stay in 1b: 1 Week
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: RAY Co. HOSP.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: RAY
c. CITY OR TOWN: ORRICK
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 413 W. ELM.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First WALTER Middle Lee Last CREASON
4. DATE OF DEATH: Month APRIL Day 14 Year 1961
5. SEX: Male
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: NOV. 7 1890
9. AGE (last birthday): 70
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: HEAVY EQUIPMENT
11. BIRTHPLACE (City and state or country): ORRICK
12. CITIZEN OF WHAT COUNTRY: USA.
13a. FATHER'S NAME: UNKNOWN
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: JULIA CREASON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: MRS. Veda PERRY Address: TOPEKA KANS.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Abdominal Viscus
DUE TO (b): "GASTRIC Ulcer"
DUE TO (c): MASSIVE INTERNAL HEMORRHAGE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 24 hrs ? 6 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ANURIA - Hypertrophied PROSTATE

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-6-61, to 4-14-61 and last saw ~~him~~ alive on 4-14-61
Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] MD
22b. ADDRESS: Richmond Mo
22c. DATE SIGNED: 4-14-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 4-14-61
23c. NAME OF CEMETERY OR CREMATORY: Salem Cemetery
23d. LOCATION (City, town, or county) (State): Independence Jackson Mo.
24. FUNERAL DIRECTOR: Geo. C. CARSON & SONS ADDRESS: INDP. MO.
25. DATE RECD. BY LOCAL REG.: 4-14-1961
26. REGISTRAR'S SIGNATURE: Mabel Jackson

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

MAY 17 1961

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.

Student_____
Signature of Student Embalmer

Signed Leroy J. Tyler

Licensed Embalmer No. 4941

P. O. Address Independence T

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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