

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024992

STATE FILE NUMBER

Registration District No. 384 Primary Registration District No. 303d Registrar's No. 409

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10580

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

FILED JUN 20 1963

a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MEADVILLE</u>		Length of stay in 1b <u>20 YRS.</u>	c. CITY OR TOWN <u>MEADVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER LEROY CREASON</u>			4. DATE OF DEATH Month Day Year <u>6-8-63</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-93</u>	9. AGE (last birthday) <u>70</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE REPAIRMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SERVICE</u>	11. BIRTHPLACE (City and state or country) <u>BROWNING Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>WALTER CREASON</u>		13b. MOTHER'S MAIDEN NAME <u>MOLLIE KIMBROUGH</u>		14. NAME OF HUSBAND, OR WIFE <u>MABEL</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>MABEL CREASON, MEADVILLE, Mo.</u> Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>HYPSTATIC PNEUMONIA</u>				<u>3 days</u>
DUE TO (b) <u>MYOCARDIAL INSUFFICIENCY</u>				<u>2 wks</u>
DUE TO (c) <u>CORONARY THROMBOSIS</u>			<u>4 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <u>5-2-63</u> to <u>6-8-63</u> and last saw her alive on <u>6-8-63</u> Death occurred at <u>12:35</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Walter Wright</u>		22b. ADDRESS <u>Wheeler Mo</u>		22c. DATE SIGNED <u>6-10-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-10-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADVILLE CEMETERY</u>	23d. LOCATION (City, town, or county) <u>MEADVILLE, Mo.</u>	
24. FUNERAL DIRECTOR <u>WRIGHT, MEADVILLE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-10-63</u>	26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>	

USE BLACK INK OR TYPEWRITER RIBBON

500-200-100

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10-09

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 *W. H. Knight*

Licensed Embalmer No. 4655

P. O. Address Meadville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.