MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

33578

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 18

City Kansas City (No. Wesley Hospital St. Ward)

2. FULL NAME John Crosby,

(a) Residence. No. Cleveland Hotel St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Wh.	Single.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *****

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 20. 1850.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	78	5	X20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Real-Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Ret. 10 yrs.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER Carlot Crosby

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N.Y.

12. MAIDEN NAME OF MOTHER Mary Hill

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) N.Y.

14. INFORMANT Fred Crosby. (Address) Lexington Mo.

15. FILED 10/10, 1928 M. M. Crowe Assr REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 10 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1928, to Oct. 10, 1928, that I last saw h[illegible] alive on Oct. 9, 1928, and that death occurred, on the date stated above, at 8a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131

Cystitis & Uremia 1351

1392

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis

(duration) yrs. mos. ds.

1290

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Test Jones, M. D

10/10/28 (Address) 802 Paseo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Viola Ill	10/12/ 1928
20. UNDERTAKER	**ADDRESS**
H. W. Gates	K.C.Ks

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.