

APR 23 1936

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

Do not use this space.

10880

1. PLACE OF DEATH

County Jackson
Township New
City Kansas City (No. 511 W. 11th)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1555
St. _____ Ward _____

2. FULL NAME

Raymond M. Crum
(a) Residence, No. 511 W. 11 St., _____ Ward _____

(If nonresident, give city or town and State)

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 6, 1878

7. AGE YEARS 57 MONTHS 2 DAYS 15 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Engineer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

FATHER 13. NAME Wm. R. M. Crum

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York City

MOTHER 15. MAIDEN NAME Furness Palmer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Routley Spgs. Pa.

17. INFORMANT (ADDRESS) Raymond M. Crum

18. BURIAL, CREMATION OR REMOVAL PLACE St. Scott DATE 3-22 1936

19. UNDERTAKER (ADDRESS) Explor. Funeral Home

20. FILED Mar 22, 1936 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/21/36, 19

22. I HEREBY CERTIFY that I attended deceased from _____, 19

I last saw him/her alive on _____, 19. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

German measles
Chronic bronchopneumonia
Date of onset _____

Other contributory causes of importance: 930

Name of operation _____ Date of operation _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide: _____ Date of injury _____, 19

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) [Signature], M. D.

(Address) [Signature]

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.

