

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.

RECD JAN 13 1939

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

41963
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kan Primary Registration District No. 1002
 (c) City Kansas City, Mo. (d) Street No. K. C. General Hospital Registered No. 5029
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

5211
Maia Catherine Crowley
 (a) Residence, No. 9619 East 9th Street St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grant T. Crosley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14th, 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 7 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. None
 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) No Record 9

FATHER 13. NAME No Record 9

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record 9

MOTHER 15. MAIDEN NAME No Record 9

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT Bruce Johnson
 (ADDRESS) 9619 East 9th, Str., K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill Cem. DATE Dec. 27, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. L. Forster
918 Brooklyn Avenue, K. C. Mo.

20. FILED 12-27-38 M. M. Crowe, Jr. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 25, 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1938, to Dec 20, 1938

I last saw him alive on Dec 25, 1938 Death is said to have occurred on the date stated above, at 3:20 a.m.

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

diabetes mellitus
Senility 59

Date of onset

Other contributory causes of importance:

Diabetic gangrene of toes

Name of operation _____ Date of _____

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 PT De Mania !, M. D.
 (Signed) _____ (Address) _____

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.