

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.

17-11 REC'D JUN 8 1939

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

17722
 Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1007
 (c) City Kansas City, Mo. (d) Street No. Large Side Hospital Registered No. 2124
 (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 Crawford (Baby)
 (a) Residence, No. 2638 Lockhart St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>5-20-1939</u>		
7. AGE	YEARS	MONTHS
	<u>0</u>	<u>0</u>
		DAYS
		<u>1</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Baby</u>	
	9. Industry or business in which work was done, as 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) <u>Kemo</u> (STATE OR COUNTRY) _____		
FATHER	13. NAME <u>Joseph H Crawford</u>	
	14. BIRTHPLACE (CITY OR TOWN) <u>2638 Lockhart</u> (STATE OR COUNTRY) _____	
MOTHER	15. MAIDEN NAME <u>Mrs. Hester Hayes</u>	
	16. BIRTHPLACE (CITY OR TOWN) <u>Kemo</u> (STATE OR COUNTRY) _____	
17. INFORMANT (ADDRESS) <u>Joseph H Crawford</u> <u>2638 Lockhart</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Washburn</u> DATE <u>5/22/39</u>		
19. FUNERAL DIRECTOR (NAME) <u>Wm. M. Brown</u> (ADDRESS) _____		
20. FILE <u>May 22 1939</u> <u>W. M. Brown</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-21-1939

22. I HEREBY CERTIFY, That I attended deceased from May 20, 1939, to May 21, 1939. I last saw him alive on May 21, 1939. Death is said to have occurred on the date stated above, at 8:30 a.m. The principal cause of death and related causes of importance were as follows:
Pulmonary hemorrhage

Date of onset 1939

Other contributory causes of importance:
Prematurity
abruptio placentae

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

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? no
 If so, specify _____
 (Signed) Margaret Jones M. D.
 (Address) 3630 Throst

W.B. Morgan Jones

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.