

**FILED MAR 11 1940**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's **620**

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Clara Pauline Cragan

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thomas Cragan 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased. 4 (Month) 25 (Day) 1886 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>9</u>	<u>16</u>	<u>hr.</u> <u>min.</u>

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation Housewife 6

11. Industry or business XX 9

12. Name John Felton

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thomas Cragan

(b) Address 2516 Belfountain

17. (a) Removal (b) Date thereof 2/11/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director Wm. P. Sheehan

(b) Address 6606 Indep. Ave. K. C. Mo.

19. (a) Feb. 11, 1940 (b) M. M. Craine  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Kansas City, Mo  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2516 Belfountain  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10th  
 year 1940 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2/7/40  
 , 1940, to 2/10/40, 1940  
 that I last saw him alive on 2/10/40  
 and that death occurred on the date and hour stated above.

Immediate cause of death Arterial and Mitral Stenosis  
920

Due to arterial congestion

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1

23. Signature D. R. Russell (M. D. or other)  
 Address 329 1/2 811 St Date signed 2/11/40

Duration 69 days  
 Underline the cause to which death should be charged statistically.

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.

JUL 21 1954

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**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.**