

Registration District No. **399**

Primary Registration District No. **1002**

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:  
**3620 Central**  
(If not in hospital or institution, write street number or location) **2**  
(d) Length of stay: In hospital or institution **22 years** (Specify whether years, months or days) **6/3**

3. (a) PRINT FULL NAME **Mrs. Carey Ella Crabtree**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Fe** 5. Color or Wh race **Wh** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Clifford J. Crabtree** 6. (c) Age of husband or wife if alive, years **1861**

7. Birth date of deceased **April 6 1861**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **2** If less than one day .hr. min.

9. Birthplace **Sioux City Iowa**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

12. Name **H. S. Church**

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

14. Maiden name **Mary Palmer**

15. Birthplace **N. Y.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Bessie Crabtree**  
(b) Address **3620 Central**

17. (a) **Removal** (b) Date thereof **May 9-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Salt Lake City, Utah**

18. (a) Signature of funeral director **J. W. Wagner**  
(b) Address **Kansas City, Mo.**

19. (a) **May 9, 1940** (b) **M. M. Craue**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3620 Central**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **8th**  
year **1940** hour **12** minute **35 A.** M.

21. I hereby certify that I attended the deceased from **Sioux City**, **1938**, to **May 8**, **1940** that I last saw her alive on **May 3**, **1940** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Embolus** Duration **3 wks**

Due to **Cerebral Embolus**

Due to **Cerebral Embolus**

Other conditions (Include pregnancy within 3 months of death) **8204E**

Major findings: Of operations

Of autopsy

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) (c) Means of injury **1**

23. Signature **Dr. J. W. Wagner** (M. D. or other) **5/8/40**  
Address **220 Professional Bldg** Date signed **5/8/40**

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

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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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address K. C. Mo

**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.**