

FILED JUL 15 1940
399

Registration District No.

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: General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6-8-40-6-9-40
In this community 1 day
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Infant Crane
3. (b) If veteran, name war _____ 3. (c) Social Security No. 650

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 6 8 1940
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day hr. _____ min.

9. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
12. Name Albert Crane
13. Birthplace Desota Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Geraldine Porter
15. Birthplace Lawrence Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof June 14-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Wm. A. Schuyler
(b) Address Gen. Hosp. #2

19. (a) June 13, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1206 E. 17th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 9
year 40 hour 2 minute 50 P.M.

21. I hereby certify that I attended the deceased from 6-8- 1940, to 6-9- 1940
that I last saw him alive on 6-9- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage Duration _____

Due to Cerebral Compression

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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) (e) Means of injury 1

23. Signature P. O. Schuyler (M.D. or other) _____
Address Gen. HOSP. #2 Date signed 6-12

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.