

FIVE JUL 15 1940

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 2440

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
I. E. F. B. M. Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 mo 11 days
 (Specify whether
 In this community 4 years
 years, months or days)

3. (a) PRINT FULL NAME Raymond Crain 650

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

4. Sex Male 5. Color or race negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mrs Margaret Crain 6. (c) Age of husband or wife if alive 25 years
 7. Birth date of deceased Nov 12 1912
 (Month) (Day) (Year)

8. AGE: Years 27 Months 6 Days 25 If less than one day
 hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER
 { 12. Name Charles Crain
 { 13. Birthplace Libonan Mo
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Cora Simpson
 { 15. Birthplace 9
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Crain
 (b) Address 1231 P. 2000

17. (a) Burial (b) Date thereof 6-22-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Cemetery18. (a) Signature of funeral director Hatkins Bros(b) Address 1721 1/2 E. 12th

19. (a) June 15 1940 (b) M. M. Brown
 (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. 1419 E. 12th
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7
 year 1940 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral acute purulent pneumonia due to emboli - 108
mult. abscesses of liver
 Due to _____
 Other conditions Non tuberculous
 (Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____

Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

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 _____

23. Signature W. H. Dyer, M.D. (M. D. or other) _____
 Address _____ Date signed _____

WRITE LEGIBLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I X19311

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.

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 P. M. Adams

Licensed Embalmer No. 4116

P. O. Address 1729 Lydia K.S.M.

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.