

AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24421**
Registrar's No. **3034**

Registration District No. **399** Primary Registration District No. **1002**

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

1. PLACE OF DEATH: **Jackson**
(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: **K.C. General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **25 days** (Specify whether **40 years**)
In this community **40 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Cross, Robt. Robert** No. **670**
3. (b) If veteran, name war **No record** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **No record**
6. (b) Name of husband or wife **No record** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **No record** (Month) (Day) (Year)

8. AGE: Years **71** Months **?** Days **?** If less than one day hr. min.

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

10. Usual occupation **No record** **9**

11. Industry or business
12. Name **No record** **9**
13. Birthplace **No record** (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 **Record clerk**
(b) Address **K.C. General Hospital No. 1**

17. (a) **Removal** (b) Date thereof **7 30 40** (Month) (Day) (Year)
(c) Place: burial or cremation **Kirksville, Missouri**

18. (a) Signature of funeral director **Weilert Funeral Home**
(b) Address **2332 Monitor Plaza, K. C. Mo.**

19. (a) **July 30, 1940** (Date received local registrar) (b) **M.M. Crowe** (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. **1200 E. 11th St.** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **26th**
year **1940** hour **9** minute **10 A.** M.

21. I hereby certify that I attended the deceased from **7-1-40**, 19____, to **7-26-40**, 19____;
that I last saw him alive on **7-26-40**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy** Duration _____

Due to **Cerebral arteriosclerosis**

Due to **62.0**

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy **None**
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? _____

23. Signature **Wm. R. Thoms** (Specify type of place) (b) Means of injury _____
Address **Med. Dir. K.C. Gen. Hospital** (c) D. or other _____
Date signed _____

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

Blaine E. Weiland

Licensed Embalmer No.

4075

P. O. Address

2332 Monitor Pl.

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.