

SEP 5 1940

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3273**

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: K.C. Gen. Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 35 years

3. (a) PRINT FULL NAME LURA CROWELL 640

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

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

6. (b) Name of husband or wife Milton 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased July 27 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 0 Days 27 If less than one day hr. min.

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

10. Usual occupation Seamstress

11. Industry or business Dress making

MOTHER FATHER
12. Name Jessiah Morgan
18. Birthplace W Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Hannah Vance
15. Birthplace W Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Vera Crowell

(b) Address 1012 East 8th St

17. (a) Burial (b) Date thereof 8/20/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Alta Vista Kansas

18. (a) Signature of funeral director Mayberry Funeral Par

(b) Address 2315 Richmond

19. (a) Aug. 19, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

0 Missouri (a) State (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3231 Prospect (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 18th
year 1940 hour 12 minute 50 A. M.

21. I hereby certify that I attended the deceased from 8-17-40, 19____, to 8-18-40, 19____;
that I last saw h. er alive on 8-18-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Pericarditis and pericardial effusion
Chronic coronary occlusion and myo-
cardial infarction

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy See above

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)
(If means of injury)
23. Signature Dr. K. J. Gen. Hospital (M. D. or other)
Address Med. Dir. K. C. Gen. Hospital, K. C. Mo. Date signed _____

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

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 Ray E. Snow

Licensed Embalmer No. 2560

P. O. Address 2315 Lincoln

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.