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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37765

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4363

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 10-28-40-11-14-40  
(Specify whether  
In this community 50 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limit, write "RURAL")  
(d) Street No. 1611 Norton Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME John Cranschaw

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Louretta Cranschaw 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) 11 (Day) 22 (Year) 1864

8. AGE: Years 75 Months 11 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-16-40 (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Walter Bros.

(b) Address 1729 Lydia

19. (a) 11-16-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14 year 40 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from 10-28- 1940 to 11-14- 1940 that I last saw him alive on 11-14- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerotic Type of Heart Disease

Due to Dementia Seniles

Due to \_\_\_\_\_

Other conditions 95% (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 A. C. Brown (M. D. or other)

Address Gen. Hosp. #2 Date signed 11-16-40

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

DEC 11 1940

MOTHER FATHER

Duration  
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 Isaac Jerome Manlove

Licensed Embalmer No. 3994

P. O. Address 1120 E. 23rd St

**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.**