

No. 2  
4-13-40  
-17-39  
X23159

ED MAR 11 1941 85

Registration District No. \_\_\_\_\_ Primary Registration District No. **1001** Registrar's No. **233**

1. PLACE OF DEATH: **BUCHANAN**  
 (a) County **BUCHANAN**  
 (b) City or town **ST. JOSEPH**  
 (c) Name of hospital or institution: **2018 FRANCOIS 1**  
 (d) Length of stay: In hospital or institution **20 YEARS.**  
 In this community **20 YEARS.**

3. (a) PRINT FULL NAME **FRED B. CROSSLEY**

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

4. Sex **MALE** 5. Color or race **WHT** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **ALMIRA CROSSLEY** 6. (c) Age of husband or wife if alive **UNKNOWN**

7. Birth date of deceased **UNKNOWN**

8. AGE:	Years	Months	Days	If less than one day
<b>Est. 72</b>	<b>?</b>	<b>?</b>	<b>?</b>	hr. min.

9. Birthplace **UNKNOWN KY.**

10. Usual occupation **RETIRED**

11. Industry or business **CONST. Supt. LEHR CONST. Co**

12. Name **STEWART CROSSLEY**

13. Birthplace **UNKNOWN KY.**

14. Maiden name **UNKNOWN**

15. Birthplace **UNKNOWN KY.**

16. (a) Informant **ARTHUR LEHR**

(b) Address **ST. JOSEPH, MO**

17. (a) **BURIAL** (b) Date thereof **3-1-41**

(c) Place: burial or cremation **Mt. Auburn Cem.**

18. (a) Signature of funeral director **FLEEMAN & SON INC**

(b) Address **ST. JOSEPH, MO**

19. (a) **3/1-1941** (b) **W.D. Neathelush**

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Mo.** (b) County **BUCHANAN**  
 (c) City or town **ST. JOSEPH**  
 (d) Street No. **224 N. 13th**  
 (e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **FEB.** day **24** 19**41** year hour **5** minutes **30 A.**

21. I hereby certify that I attended the deceased from **Feb. 19** 19**41** to **Feb 23** 19**41** that I last saw him alive on **Feb. 23** 19**41** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thromb.**

Due to **arterio scl. gen.**

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

Other conditions **Influenza 24** (Include pregnancy within 3 months of death) **9/19/41**

Major findings: Of operations **None**

Of autopsy **None**

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? \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? **85**

(e) While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (f) Means of injury \_\_\_\_\_

23. Signature **W.D. Neathelush** (M. D. or other) **M.D.** Address **Kempner Bldg** Date signed **2/27/41**

Duration
<b>2/24/41</b>
<b>9/19/41</b>

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

*Geo. E. Daniel*

Licensed Embalmer No.

*3300*

P. O. Address

*St. Joseph, Mo.*

**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, fact should be so stated above.**