

**RURAL MAR 2 1942**  
Registration District No. 1002

Primary Registration District No. 1002

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

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:  
22 West 65th Terrace, /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X (Specify whether  
7 months, years, months or days)

In this community 7 months,

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. 22 West 65th Terrace,  
(If rural, give location)

(e) Citizen of foreign country? X (Yes or No)  
If yes, name country X M.

3. (a) PRINT FULL NAME Mrs. Rose Irene Christiansen,

3. (b) If veteran, name war X

3. (c) Social Security No. NO.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Charles P. Christiansen

6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased May 28 1885  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>8</u>	<u>21</u> <sup>23</sup>	<u>hr.</u> <u>min.</u>

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

10. Usual occupation at home,

11. Industry or business X

12. Name Unk Testebl,

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 C. R. Christiansen,

(b) Address 22 W. 65th Ter., Kansas City, Mo.

17. (a) Removal, (b) Date thereof 2-21-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation San Francisco, California

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 2/29/42 (b) M. M. Crowl  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 21st  
year 1942 hour 3:00 minute A. M.

21. I hereby certify that I attended the deceased from 1942 to 1942  
that I last saw Robert Crown on 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Thrombocytopenic Purpura

Due to 55E

Other conditions 55E  
(Include pregnancy within 3 months of death)

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 3

23. Signature Russell J. ... (M. D. or other) \_\_\_\_\_  
Address K.C. Mo. Date signed \_\_\_\_\_

Dr. Hanna M. A. Prof. Bldg.,  
Vi. 4383

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**