

FILED OCT 20 1942

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 3570

48
3
8

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: K.C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community none
years, months or days)

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. 547 1/2 Main St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT

FULL NAME ROBERT CRANE

3. (b) If veteran, name war No record

3. (c) Social Security

No. none

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced 9 No record

6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive No record years

7. Birth date of deceased (Month) (Day) (Year) No record

8. AGE: Years 74 Months no record Days 9 If less than one day hr. min.

9. Birthplace (City, town, or county) no record (State or foreign country) 9

10. Usual occupation no record

11. Industry or business ---

12. Name no record

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

14. Maiden name no record

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

16. (a) Informant Record clerk
(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Under

18. (a) Signature of funeral director Wanda Johnson

(b) Address City

19. (a) 10-6-42 (b) W. M. Crowe (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9th year 1942 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from 9-8-42, 19... to 9-9-42, 19...; that I last saw him alive on 9-9-42, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death

CEREBRAL HEMORRHAGE

Due to 82a

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

Duration

PHYSICIAN

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

23. Signature Wm. R. Johnson (M. D. or other) 0
Address Med. Dir. K.C. Gen. Hospital 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.....

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.