

FILED DEC 18 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39623**
4495

Registration District No. **149** Primary Registration District No. **1002** Registrar's No. _____

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 **2708 Park 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In-hospital or institution **9 days**
In this community **9 days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Ida Crauthers**

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

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Tom Crauthers** 6. (c) Age of husband or wife if alive **67** years
7. Birth date of deceased **12-25-1881**
(Month) (Day) (Year)

8. AGE: Years **60** Months **11** Days **6** If less than one day hr. _____ min. _____

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

10. Usual occupation **House Work**

11. Industry or business **own home**

12. Name **Silas Barton**

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

14. Maiden name **Harriet Erickson**

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

16. (a) Informant **Tom Crauthers**

(b) Address **2918 Sherman**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-5-42**
(Month) (Day) (Year)

(c) Place: burial or cremation **Westlawn**

18. (a) Signature of funeral director **Mrs. W. Jones**

(b) Address **440 State St.**

19. (a) **12-4-42** (Date received local registrar) (b) **M. M. Crowe** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Wyandotte**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2918 Sherman**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **1**
year **1942** hour **4** minute **13 P.** M.

21. I hereby certify that I attended the deceased from **Nov 14** 19**42** to **Dec 1** 19**42**
that I last saw **her** alive on **Dec 1** 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy** Duration **24hr**

Due to **Aneurysm Heart** ?

Due to **9315**

Other conditions **9315**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 **Arthur Jones** (M.D. or other) _____
Address **2918 Sherman** Date signed **12/2/42**

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

MOTHER FATHER

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.

Signature

Bugard English

Licensed Embalmer No. *4405*

P. O. Address *4400 State St. C.*

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.