

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2398

ED JUN 7 1943
Registration District No. 749

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 Lakeside Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks
(Specify whether years, months or days)

In this community 3 Weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Allen 999

(c) City or town Iola 17
(If outside city or town limits, write "RURAL")

(d) Street No. 634 North 1st Street
(If rural, give location) 2

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mr. Walter Scott Cruse

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

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Louise Cruse
6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased July 20 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>10</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Kiln Operator - Retired

11. Industry or business Lee High Cement Company

MOTHER FATHER

12. Name Noah Cruse

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 Mrs. Louise Cruse

(b) Address Iola, Kansas

17. (a) Removal (b) Date thereof May 26th, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Iola, Kansas

18. (a) Signature of funeral director D. W. Newcomb

(b) Address 1401 Brush Creek Blvd.

19. (a) 5-26-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26th
year 1943 hour 3 minute 45 A. M.

21. I hereby certify that I attended the deceased from May 5 1943 to May 26 1943
that I last saw him alive on May 25 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Abscess
Meningitis
Due to _____

Due to Spinal fluid finding: Staph and blood

Other conditions 80a
(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) (2) Means of injury

23. Signature L. J. Graham (M. D. or other) J. D.
Address 811 Chandler Bldg Date signed 5-26-43

Duration 1 mo or longer
PHYSICIAN
Underline the cause to which death should be charged statistically.

12-
Chambers Bldg
S

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 *K C Newcomer Jr*
Licensed Embalmer No. 41045
P. O. Address *K C 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.