

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 13 1943

Registration District No. _____

Primary Registration District No. 100V

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:
1304 West 50th Street,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NO.
In this community 56 years, (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Robert French Crawford,

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Anna Bland Crawford 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased February 16 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 7 87 hr. min.

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

10. Usual occupation Implement Business

11. Industry or business X

MOTHER FATHER { 12. Name James Crawford,

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

14. Maiden name Phoebe Guthrie

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

16. (a) Informant Mrs. C. G. Logan,

(b) Address 1304 W. 50th St., Kansas City, Mo.

17. (a) Cremation (b) Date thereof 9-25-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

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

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

19. (a) 9-24-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

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. 1304 West 50th Street,
(If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 23rd
year 1943 hour 5:00 minute a. M.

21. I hereby certify that I attended the deceased from Aug 1943 to Sept 22 1943
that I last saw him alive on Sept 22 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to _____

Due to 9/22

Other conditions (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)

(e) Means of injury Car

23. Signature W. B. Brown (M. D. or other) MD

Address 608 West 12th St Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. H. L. Mantz

Prof. by V: 0840
618

0840
m

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.