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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24147

Registration District No. 147 Primary Registration District No. 5569 Registrar's No. 197

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (8) R.R.#3 Brookline
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 9105 East 69th. Terrace
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 25 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City R.R. "# 3 0
(If outside city or town limits, write "RURAL")

(d) Street No. 9105 East 69th. Terrace 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Amy E. Cracraft

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Howard R. Cracraft

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased 5 (Month) 19 (Day) 1897 (Year)

8. AGE: Years	Months	Days	If less than one day
48	0	2	hr. min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Morie Shaklee
13. Birthplace Rossville (City, town, or county) Kansas (State or foreign country)

MOTHER
14. Maiden name Lida
15. Birthplace Danville (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mr. Howard R. Cracraft
(b) Address 9105 East 69th. Terrace

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address Kansas City, Mo.

19. (a) 5-22-45 (Date received local registrar) (b) M Garvin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st. year 1945 hour 5/50 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1945 to May 21st 1945 that I last saw her alive on May 21st 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	6 hrs
Due to Vicious hypertension	years
Due to Chronic Myocarditis	years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

94W

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? ..... (Specify type of place)
While at work? (e) Means of injury .....

23. Signature Theodore Corcangeo (M. D. or other) D.O.
Address Raytown Date signed 5/22/45

1159

(Licensed Embalmer's Statement on Reverse Side)

Dr. Carcanges Raytown , Mo.

Fl.1314

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 Orland M. Minor

Licensed Embalmer No. 3414

P. O. Address 918 Brooklyn

Kansas City

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.