

State File No.
Registrar's No.

FILED NOV 14 1945
Registration District No. 199

Primary Registration District No. 1002

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

48
3
8

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:
210 North Monroe
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 45 Years years, months or days)

3. (a) PRINT FULL NAME Everlee Cravens

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 Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 10 8 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

54 0 23 hr. min.

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

10. Usual occupation Invalid

11. Industry or business _____

MOTHER FATHER

12. Name William B. Cravens

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

14. Maiden name Esther Drake

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

16. (a) Informant Clara Franke

(b) Address 210 N. Monroe

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-1945
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address Kansas City, Missouri

19. (a) 11-1-45 (Date received local registrar)

(b) Geraldine Holmes (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. 210 North Monroe
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 1st.
year 1945 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from any 1935, to 11-1 1945
that I last saw her alive on 10-30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death mitral stenosis cerebral hemorrhage

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 92 B

Major findings: Of operations _____

Of autopsy _____

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 H. H. Quinn (M. D. or other) MD
Address 1034 Rialto Date signed 11-1-45

Dr. H.H.Owens
Rialto Bldg.

Vic 2813

10-1-19

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

working under my personal supervision.

Registered Apprentice No. _____

Signed Sharon A. Redman

Licensed Embalmer No. 2737

P. O. Address H.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.