

V. S. No. 2
00M-5-43
Rev. 5-17-39
I X26671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
9 1946 STANDARD CERTIFICATE OF DEATH
THE STATE BOARD OF HEALTH OF MISSOURI

State File No. **40056**
Registrar's No. **5192**

Registration District No. **149** 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 **HANSAAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST MARYS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 WEEKS 4 DAYS**
In this community **5 wks. 4 days**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **CASS** **19**
(c) City or town **BELTON** **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. **1**
(If rural, give location)
(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **WALTER WILLIAM CROW**
3. (b) If veteran, name war **✓ NO**
3. (c) Social Security No. **486-09-2983**
4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **CLER B. CROW**
6. (c) Age of husband or wife if alive **52** years
7. Birth date of deceased **JUNE 1 1880**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **16th**
year **1945** hour **6** minute **0** A.M.
21. I hereby certify that I attended the deceased from **July 12, 1945**
19 to **12-16-** **1945**
that I last saw him alive on **12-5-45**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
65 **6** **15** hr. min.

Immediate cause of death
Sub-acute Hemeralo Nephritis
caused by Micrococcal Septicemia and
Due to Bacterial fibrinemia
skin rash & possibly allergic
from Sulfa drugs

9. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)
10. Usual occupation **SALESMAN**
11. Industry or business **HOOVER Bros. School Sup.**

Other conditions (Include pregnancy within 3 months of death)
Major findings: **None**
Of operations **None performed.**
Of autopsy **None performed.**
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

MOTHER FATHER
12. Name **WILLIAM CROW**
13. Birthplace **UNK.** **4**
(City, town, or county) (State or foreign country)
14. Maiden name **MARTHA JANE WALKER**
15. Birthplace **Ky.** **1**
(City, town, or county) (State or foreign country)
16. (a) Informant **MRS. W.W. CROW**
(b) Address **BELTON, MO.**
17. (a) **BURIAL** (b) Date thereof **DEC. 18, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **BELTON, MO.**
18. (a) Signature of funeral director **E.T. George Law**
(b) Address **Belton, Mo.**
19. (a) **12-18-45** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

23. Signature **W. W. Crow** (M. D. or other)
Address **Kassia City, Mo** Date signed **1/17/46**

Statist. Bury

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 A. T. George

Licensed Embalmer No. 3645

P. O. Address Georgetown, Md.

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: