

S. No. 2
M-5-43
v. 5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENTRAL REGISTER
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27074
Registrar's No. 3547

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 Kansas City
(If outside city or town limits, write "RURAL", and name of township)
(c) Name of hospital or institution: General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days) 14 YEARS

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. 547 Walnut
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Wesley Crow
3. (b) If veteran, name war No
3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 16
year 1946 hour 7 minute 20 P.M.
21. I hereby certify that I attended the deceased from Aug. 10, 1946, to Aug. 16, 1946;
that I last saw him alive on Aug. 16, 1946
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife MRS. MALINDA KELLER CROW
6. (c) Age of husband or wife if alive 87 years
7. Birth date of deceased OCTOBER 13 1858
(Month) (Day) (Year)

Immediate cause of death
Generalized arteriosclerosis
Cerebral thrombosis with
encephalomalacia-Terminal
Due to bronchopneumonia

8. AGE: Years Months Days If less than one day
87 10 3 hr. min.

Other conditions (Include pregnancy within 3 months of death)
§3 b

9. Birthplace NOBEL COUNTY OHIO
(City, town, or county) (State or foreign country)
10. Usual occupation RETIRED - 20 YEARS
11. Industry or business REAL ESTATE
12. Name MARTIN CROW
13. Birthplace OHIO
(City, town, or county) (State or foreign country)
14. Maiden name MARTHA RAY
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy See above

16. (a) Informant Olathe Kanagy RB #2
(b) Address Mrs Nellie A. Gross
17. (a) CREMATION (b) Date thereof AUG-19-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation D.W. NEWCOMERS SONS
18. (a) Signature of funeral director D.W. Newcomers Sons
(b) Address 1401 BRUSH CREEK BLVD.
19. (a) 8-17-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____
23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 8-17-46

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address F. 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.