

FILED APR 8 1947

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **1358**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Lake Side Hosp. K.C., Mo.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 Days**
(Specify whether years, months, days)

In this community **15 days**
(Specify whether years, months, days)

3. (a) PRINT FULL NAME **Mr. F. E. CRAWFORD**

3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Etzel**
6. (c) Age of husband or wife if alive **58** years
7. Birth date of deceased **July 25th 1880**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 07 29 hr. min.

9. Birthplace **Kearney Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Mechanic**

11. Industry or business **Gen. Mechanic**

12. Name **Matthew Everett Crawford**

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

14. Maiden name **Mabel Garrison**

15. Birthplace **Louisville Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Etzel Crawford**

(b) Address **Holt Mo.**

17. (a) **Burial** (b) Date thereof **Mar 25 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Autiock Holt, Mo.**

18. (a) Signature of funeral director **Leonard Fox**

(b) Address **Kearney Mo.**

19. (a) **3-24-47** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **24**
(c) City or town **Holt - Mo.** 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **24th**
year **1947** hour **8** minute **A.** M.

21. I hereby certify that I attended the deceased from **Mar 9th**
1947, to **Mar 24th 1947**
that I last saw him alive on **Mar 24th**
and that death occurred on the date and hour stated above. **1947**

Immediate cause of death
Cardiac failure due to
myocardial degeneration
Due to **ruptured gal bladder et** 17 days
perforated duodenum ulcer et
Due to **sub pleuronic abscess** 17 days
et hepatic abscess
Other conditions **pneumonia bacterial** 3 days
(Include pregnancy within 3 months of death)
post-operative

Duration

PHYSICIAN

Major findings:
Of operations **as above**
Of autopsy **✓ 1178**
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 **✓**
Signature **Alfred E. Scimille MD** (M.D. or other)
Address **612 Chambers Bldg. K.C., Mo.** Date signed **3-24-47**

FORWARD

1958

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

Leonard Fry

Licensed Embalmer No. 1677

P. O. Address. Kearney 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.