

No. 3900
4-10-47
5-17-39
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MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26230**
Registrar's No. **3414**

FILED SEP 4 1948
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. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **12 DAYS** (Specify whether
In this community **2 yrs 11 mo.** years, months or days) (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON 48**

(c) City or town **KANSAS CITY 3**
(If outside city or town limits, write "RURAL")

(d) Street No. **1119 TRACY 8**
(If rural, give location) **0**

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

3: (a) PRINT FULL NAME **MARIAH CRUMP**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **FEMALE 3**

5. Color or race **NEGRO**

6. (a) Single, widowed, married, divorced **WIDOWED 2**

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

7. Birth date of deceased **SEPTEMBER 6, 1856**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
91	11-9	15	hr. _____ min.

9. Birthplace **Edwardsville MISSOURI Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____

MOTHER FATHER {

12. Name **UNKNOWN Jerry Walton 9**

13. Birthplace **UNKNOWN** (City, town, or county) (State or foreign country) **9**

14. Maiden name **UNKNOWN Susan**

15. Birthplace **UNKNOWN** (City, town, or county) (State or foreign country) **9**

16. (a) Informant **ROSCOE CRUMP (SON)**

(b) Address **1119 TRACY**

17. (a) **Exposure 15** (Burial, cremation, or removal) (b) Date thereof **8/23/48**
(Month) (Day) (Year)

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

18. (a) Signature of funeral director **[Signature]**

(b) Address **[Address]**

19. (a) **8-24-48** (Date received local Registrar) (b) **[Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **21**,
year **1948** hour **9:** minute **15 A.** M.
AUGUST

21. I hereby certify that I attended the deceased from **9,** 19 **48** to **AUGUST 21,** 19 **48**
that I last saw her alive on **AUGUST 21,** 19 **48**,
and that death occurred on the date and hour stated above.

Immediate cause of death

1. GENERALIZED ARTERIO-SCLEROSIS

2. CEREBRAL ARTERY THROMBOSIS

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
- Of operations **83.8**

- Of autopsy _____

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 _____ (Specify type of place) (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **[Signature]**
Address **GENERAL HOSPITAL NO. 2** Date signed **8/21/48**

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.