S. No. 300
v. 10.48

FILED MAY 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16852

BIRTH NO. 220.36-50 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2154

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

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
c. LENGTH OF STAY (In this place): 14 DA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FAIRMOUNT HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: JACKSON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
d. STREET ADDRESS (If rural, give location): 1414 E 27

341 C

3. NAME OF DECEASED (Type or Print)
a. (First): MAX
b. (Middle):
c. (Last): McCRORY

4. DATE OF DEATH (Month) (Day) (Year): MAY 5 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: APR. 21-1950
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 14; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): X
10b. KIND OF BUSINESS OR INDUSTRY: X
11. BIRTHPLACE (State or foreign country): KANSAS CITY, MO.
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13a. FATHER'S NAME: X
13b. MOTHER'S MAIDEN NAME: JANET McCRORY
14. NAME OF HUSBAND OR WIFE: X

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: X
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: FAIRMOUNT HOSPITAL - 1414 E. 27

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Inanition
DUE TO (c): Exhaustion & Starvation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Prematurity

INTERVAL BETWEEN ONSET AND DEATH: 776X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* APRIL 21, 1950, *to* MAY 5, 1950, *that I last saw the deceased alive on* MAY 4, 1950, *and that death occurred at* 6:15A. *m., from the causes and on the date stated above.*

23a. SIGNATURE R. C. Jeffries MD (Degree or title): R. C. Jeffries M.D.
23b. ADDRESS: 6314 Brookside Plaza
23c. DATE SIGNED: 5-5-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: May-11-50
24c. NAME OF CEMETERY OR CREMATORY: Green Lawn
24d. LOCATION (City, town, or county) (State): Hickman Mills Mo

DATE REC'D BY LOCAL REG.: 5-10-50
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: A P Doehler
ADDRESS: 1415 E 15

(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed, Student Embalmer No. ..... working under my personal supervision.

Signed N P Doehler

Signed ..... Student Embalmer

Licensed Embalmer No. 1166

P. O. Address 1415 E 15

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.