

FILED SEP 25 1950

STANDARD CERTIFICATE OF DEATH

State File No. **29444**

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1047</u>		
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>OR TOWN</u> <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>12 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>OR TOWN</u> <u>St. Joseph</u>		0117		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2.</u>				d. STREET ADDRESS (If rural, give location) <u>514 South 2nd.</u>				
3. NAME OF DECEASED (Type or Print) <u>JOHN</u>			a. (First)		b. (Middle) <u>R. A.</u>		c. (Last) <u>CROSSLAND.</u>	
4. DATE OF DEATH		(Month) (Day) (Year)		<u>9-12-1950.</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>1862</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>?</u>	IF UNDER 1 YEAR Days <u>?</u>	IF UNDER 1 YEAR Hours <u>?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Doctor of medicine</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Hattie Crossland.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>S.E. Sasser M.D., St. Joseph, Mo.</u>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostated Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility with Social Anxieties</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 year</u> <u>522X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>8-30-1950</u> , to <u>9-12-1950</u> , that I last saw the deceased alive on <u>9-12-1950</u> , and that death occurred at <u>8:43 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>J. H. Maroney M.D.</u>				23b. ADDRESS <u>State Hospital No. 2.</u>		23c. DATE SIGNED <u>9-12-1950.</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Sept. 16, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ashland cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo</u>		
DATE REC'D BY LOCAL REG. <u>Sept. 16, 1950</u>		REGISTRAR'S SIGNATURE <u>E. G. Jenkins</u>		382		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Beatrice Gray 815 1/2 1st St</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Eric J. Cheney

Signed.....
Student Embalmer

Licensed Embalmer No. 449

P. O. Address. St. Joseph, 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.