

FILED SEP 14 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26092

State File No. \_\_\_\_\_

3772

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City, Missouri</u>		c. LENGTH OF STAY (in this place) <u>5 weeks</u>		c. CITY OR TOWN <u>MISSION HILLS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>0</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>5314 MISSION WOODS RD.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>PATRICIA</u>			b. (Middle) <u>M.</u>		c. (Last) <u>CROOKS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 26 1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>5-13-1902</u>		9. AGE (In years last birthday) <u>53</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Du Quion, Illinois</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Riley Burke</u>			13b. MOTHER'S MAIDEN NAME <u>Ollie Wiggs</u>			14. NAME OF HUSBAND OR WIFE <u>Alfred J. Crooks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Alfred J. Crooks 5314 Mission Woods Rd</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant Glioma of Brain</u>				INTERVAL BETWEEN ONSET AND DEATH  <u>193+</u>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <u>H. Frank Holman</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>St. Joseph Hosp</u>			23c. DATE SIGNED <u>8-27-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-29-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulcher Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>				
DATE REC'D BY LOCAL REG. <u>8-27-55</u>		REGISTRAR'S SIGNATURE <u>Reva Minshall</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Melody-McGilley-Bylar 1800 E. Linwood</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

APR 29 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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*J. H. Payne*

Licensed Embalmer No. 2899

P. O. Address..... K

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.