

FILED AUG 1 - 1957

THE DEPARTMENT OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH24486
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3080

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|---|----------------------------------|--|--|--|---|---|-------|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL | | Length of stay in lb 40 days | | d. STREET ADDRESS (If outside, give location) 1012 N. 8th | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CLARENCE Middle Cecil Last CRAWFORD | | | | 4. DATE OF DEATH Month July Day 2 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH March 5, 1880 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Assit. Supt. Railway mail | | 10b. KIND OF BUSINESS OR INDUSTRY Railway mail | | 11. BIRTHPLACE (City and state or country) Lebanon, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James R. Crawford | | | | 14. MOTHER'S MAIDEN NAME Margaret White | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. SAW none | | 17. INFORMANT Address VA Hospital Official Records, K. C. Mo. | | | |
| 18. CAUSE OF DEATH - [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic irreversible congestive heart failure with electrolyte imbalance Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4200 | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____ | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from May 21, 1957 to July 2, 1957 Death occurred at 2:50 AM on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Geo. F. Andrews, M.D. (Degree or title) | | | | 22b. ADDRESS VA Hospital K.C. MO. | | 22c. DATE SIGNED 7/2/57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7/5/57 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 23d. LOCATION (City, town, or county) (State) Kansas City, Ks. | | | |
| 24. FUNERAL DIRECTOR Geo. F. Porter & Sons | | ADDRESS K.C.Ks. | 25. DATE RECD. BY LOCAL REG. 7-3-57 | 26. REGISTRAR'S SIGNATURE Neva Minshel | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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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.....
Howard L. Pater

Licensed Embalmer No. 3751

P. O. Address 19th & Mir
Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.