

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009875

STATE FILE NUMBER
1522

FILED APR 9 1958

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

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
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 Our Lady of Mercy Home 918 E. 9th		Length of stay in lb 9 yrs	d. STREET ADDRESS (If outside, give location) 918 E. 9th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) MISS BEECE CRANE			4. DATE OF DEATH Month March Day 24 Year 1958		
First	Middle	Last			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1870	9. AGE (In years last birthday) 87	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) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Aurora, Illinois	12. CITIZEN OF WHAT COUNTRY? U. S. A.
-----------------------------------------------------------------------------------------------------------------	--------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------

13a. FATHER'S NAME Michael Crane	13b. MOTHER'S MAIDEN NAME Bridget Gaughan	14. NAME OF HUSBAND OR WIFE None
--------------------------------------------	-----------------------------------------------------	--------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Albert W. Baumgardner, 5739 Holmes
------------------------------------------------------------------------------------------------------------------------	----------------------------------------	----------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) General arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) 2
-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 June 25-30-3-24-58 and last saw her ^{him} live on 3-22-58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. H. Owens M.D.	22b. ADDRESS 1034 Prairie Bldg	22c. DATE SIGNED 3-24-58
-------------------------------------------------------------	------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-24-1958	23c. NAME OF CEMETERY OR CREMATORY Chanute Ks. Cem.	23d. LOCATION (City, town, or county) (State) Chanute, Kansas
-------------------------------------------------------------	-------------------------------	---------------------------------------------------------------	-------------------------------------------------------------------------

24. FUNERAL DIRECTOR Melody-McGilley-Eylar Funeral Home Woodland-Linwood	ADDRESS Woodland-Linwood	25. DATE REC'D. BY LOCAL REC. 3-24-58	26. REGISTRAR'S SIGNATURE neva minihall
---------------------------------------------------------------------------------------	------------------------------------	-------------------------------------------------	---------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

H. H. Owens

All diseases in Part I must be causally related.

*The High Co.
Ralls, Mo.*

2

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

Licensed Embalmer No.
P. O. Address *KC*

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.