

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032612

STATE FILE NUMBER

FILED SEP 24 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4155

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. Hospital			Length of stay in lb 2 days		d. STREET ADDRESS (If outside, give location) 3217 Delavan		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First EARL Middle S Last CRANDALL				4. DATE OF DEATH Month 8th Day 31st Year 1958									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-92		9. AGE (In years last birthday) 65 yrs		10. FUNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer self				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and state or country) Brookfield, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.					
13a. FATHER'S NAME Albert Crandall				13b. MOTHER'S MAIDEN NAME *M. Lydia Crandall				14. NAME OF HUSBAND OR WIFE Grace Crandall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. none		17. INFORMANT Address V.A. Hospital 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 Lobar Pneumonia, left lung										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) carcinoma of rectum										154			
DUE TO (c)													
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 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.)										
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>													
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 August 29, 1958 to August 31, 1958 and attended death occurred at 3:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) E. Foroughi M.D.						22b. ADDRESS MD V.A. Hospital, Kansas City, Mo			22c. DATE SIGNED 8-31-58				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/1/58		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.			23d. LOCATION (City, town, or county) (State) Kansas City, Kansas						
24. FUNERAL DIRECTOR Ralph Hulton, Kansas City, Ks.				25. DATE RECD. BY LOCAL REG. 9-1-58		26. REGISTRAR'S SIGNATURE Neva Marshall							

doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

E. Foroughi



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 *Ralph Fulton*

Licensed Embalmer No. *3035*

P. O. Address

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.