

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032613

STATE FILE NUMBER  
4174

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

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL INSTITUTE <i>3300 Chestnut</i>		Length of stay in lb <i>54 yrs.</i>	d. STREET ADDRESS (If outside city location) <i>3300 Chestnut</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>B.</i> Last <i>Crane</i>			4. DATE OF DEATH Month <i>Aug</i> Day <i>31</i> Year <i>1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 29 1901</i>		9. AGE (In years last birthday) <i>56</i> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Warehouseman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>		11. BIRTHPLACE (City and state or country) <i>Brookfield, Mo.</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						

13a. FATHER'S NAME <i>Robert Lee Crane</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Ann Weir</i>		14. NAME OF HUSBAND OR WIFE <i>Ann Crane</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <i>Yes. W.W. # 142</i>		16. SOCIAL SECURITY NO. <i>486-85-3210</i>		17. INFORMANT <i>Mrs. Ann Crane</i> Address <i>3300 Chestnut K.C. Mo.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>unknown</i>			INTERVAL BETWEEN ONSET AND DEATH  <i>77=5</i>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) _____ 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 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					

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 _____, to _____ and last saw <sup>her</sup> <sub>him</sub> alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>H. L. Dwyer</i> (Degree or title) <i>M.D.</i>			22b. ADDRESS <i>City Hall Kansas City Mo</i>		22c. DATE SIGNED <i>9-2-58</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Sept 2-1958</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Floral Hills Cemetery</i>		23d. LOCATION (City, town, or country) (State) <i>Kansas City, Mo.</i>	
24. FUNERAL DIRECTOR <i>C.H. Blackman &amp; Son Inc.</i>			25. DATE RECD. BY LOCAL REG. <i>9-2-58</i>		26. REGISTRAR'S SIGNATURE <i>Reva. Minshall</i>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

H. L. Dwyer

All diseases in Part I must be causally related. All diseases in Part I must be causally related. All diseases in Part I must be causally related.



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 *W.C. Reine* .....

Licensed Embalmer No. *4879* .....

P. O. Address *K.C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.