

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036330

STATE FILE NUMBER

4933

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1958

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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 Menorah Hospital		Length of stay in 1b 53 yrs.	d. STREET ADDRESS (If outside, give location) 3512 Independence Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JASON Middle V. Last CRAWFORD			4. DATE OF DEATH Month Oct. Day 16, Year 1958			
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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 March 14, 1876	9. AGE (In years last birthday) 82 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager	10b. KIND OF BUSINESS OR INDUSTRY Apt. Bldg.	11. BIRTHPLACE (City and state or country) Montrose, Ia.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Issac Crawford		13b. MOTHER'S MAIDEN NAME Charity Brown		14. NAME OF HUSBAND OR WIFE Melitta L. Crawford	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Melitta L. Crawford - 3512 Indep. Ave.		
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Interstitial pneumonia			INTERVAL BETWEEN ONSET AND DEATH 9-15-58 4 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Prostatic hypertrophy		
	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 checked="" 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.)		
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21. I attended the deceased from Death occurred at <u>9:30</u> <u>10-8-58</u> to <u>10-16-58</u> and last saw her/him alive on <u>10-16-58</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
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22a. SIGNATURE (Degree or title) E. L. Petry M.D.		22b. ADDRESS 701 E. 63rd St. - K.C., Mo.		22c. DATE SIGNED 10-17-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-20-58	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City 33, Mo.
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24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Bylar 1800 Linwood		25. DATE RECD. BY LOCAL REG. 10-20-58	26. REGISTRAR'S SIGNATURE Neva Marshall
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(Licensed Embalmer's Statement on Reverse Side)

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

E. L. Petry

S. 300
v. 1-57

FILED NOV 7 1958

1. PLACE OF DEATH

a. COUNTY **Jackson**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Kansas City**

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Menorah Hospital**

Length of stay in 1b **53 yrs.**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY **Jackson**

c. CITY OR TOWN **Kansas City**
Inside Limits
Yes No

d. STREET ADDRESS (If outside, give location) **3512 Independence Ave**
Reside on Farm
Yes No

3. NAME OF DECEASED (Type or print)
First **JASON** Middle **V.** Last **CRAWFORD**

4. DATE OF DEATH
Month **Oct.** Day **16,** Year **1958**

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH
March 14, 1876

9. AGE (In years last birthday) **82**
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Manager

10b. KIND OF BUSINESS OR INDUSTRY
Apt. Bldg.

11. BIRTHPLACE (City and state or country)
Montrose, Ia.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13a. FATHER'S NAME
Issac Crawford

13b. MOTHER'S MAIDEN NAME
Charity Brown

14. NAME OF HUSBAND OR WIFE
Melitta L. Crawford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service)
NO

16. SOCIAL SECURITY NO.
None

17. INFORMANT Address
Mrs. Melitta L. Crawford - 3512 Indep. Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Diffuse Interstitial pneumonia**

INTERVAL BETWEEN ONSET AND DEATH
9-15-58

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **Prostatic hypertrophy**

4 yrs

525X

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 NO)

20a. ACCIDENT SUICIDE HOMICIDE

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. _____

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 Death occurred at 9:30 10-8-58 to 10-16-58 and last saw her/him alive on 10-16-58 on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
E. L. Petry M.D.

22b. ADDRESS
701 E. 63rd St. - K.C., Mo.

22c. DATE SIGNED
10-17-58

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE
10-20-58

23c. NAME OF CEMETERY OR CREMATORY
Floral Hills Cemetery

23d. LOCATION (City, town, or county) (State)
Kansas City 33, Mo.

24. FUNERAL DIRECTOR ADDRESS
Melody-McGilley-Bylar 1800 Linwood

25. DATE RECD. BY LOCAL REG.
10-20-58

26. REGISTRAR'S SIGNATURE
Neva Marshall



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 *Melvin Barton*

Licensed Embalmer No. *4903*
P. O. Address *KC 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.