

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021286

FILED JUL 8 1959

Registration District No. 149

Primary Registration District No. 1002

STATE FILE NUMBER 2922  
Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hosp.</b>		Length of stay <b>3 1/2</b> mths	d. STREET ADDRESS (If outside, give location) <b>1508 East 50th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Olive</b> Middle Last <b>Crawford</b>			4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1885</b>
9. AGE (In years last birthday) <b>74</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas City, Kansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>D. A. MCKINZIE</b>	13b. MOTHER'S MAIDEN NAME <b>JOSEPHINE ELLIS</b>
14. NAME OF HUSBAND OR WIFE <b>Cyrus Foss Crawford</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>514 09 2026</b>
17. INFORMANT <b>Mrs. J.E. Herndon</b>		Address <b>1508 East 50th St. K.C. MO</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebralopathy</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension Cardio Renal Disease</b> DUE TO (c) <b>Chronic congestive heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
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.)	
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 <b>Nov - 1958</b> to <b>6/14/59</b> and last saw her/him alive on <b>6/13/59</b> Death occurred at <b>5:15 p.m.</b> m on the date/stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree & title) <b>J. J. Farnsworth M.D.</b>		22b. ADDRESS <b>1103 Grand K.C. MO</b>	22c. DATE SIGNED <b>6/15/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>JUNE 16, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>D.W. NEWCOMER'S SONS</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO.</b>
24. FUNERAL DIRECTOR <b>D.W. Newcomers Sons Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-16-59</b>	26. REGISTRAR'S SIGNATURE <b>neve munschell</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

732

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 *Norman W. Lawson* .....

Licensed Embalmer No. *4889* .....

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.