

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025279
STATE FILE NUMBER

FILED JUL 17 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3207

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 Clay	
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 Bladestown Kansas City Mo
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp. 10 Min		Length of stay in 1b 600	d. STREET ADDRESS (If outside, give location) 7017 N. Campbell
3. NAME OF DECEASED (Type or print) First Infant Middle McCrackin Last McCrackin		4. DATE OF DEATH Month 6 Day 24 Year 59	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) Months - Days - Hours - Min. 10
11. BIRTHPLACE (City and state or country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Orval Paul McCrackin		13b. MOTHER'S MAIDEN NAME Shirley Ann Locher	
14. NAME OF HUSBAND OR WIFE -		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -	
16. SOCIAL SECURITY NO. -		17. INFORMANT Shirley Locher McCrackin	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immaturity			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating 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) 776X			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.			
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 2:35AM 6/24/59 to 2:55AM 6/24/59 and last saw him alive on 6-24-59 2:54AM Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Geo. Cooper M.D. (Degree or title)		22b. ADDRESS 1220 E. 91st K.C., MO	
22c. DATE SIGNED 6-24-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-24-59 Disposal in Hosp. laboratory	23b. DATE 6-24-59	23c. NAME OF CEMETERY OR CREMATORY Kansas City Missouri	
24. FUNERAL DIRECTOR St. Joseph Hosp. 19. c. mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 6-30-59	26. REGISTRAR'S SIGNATURE Neva Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Leo F. Cooper

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

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.