

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029018

FILED VS SEP 4 1959 149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4095 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in lb <u>54 yrs.</u>	c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LAKE SIDE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>317 So. VAN BRUNT</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE CLIFFORD CRANEY</u>			4. DATE OF DEATH Month Day Year <u>AUGUST 22 1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1878</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>81</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	11. BIRTHPLACE (City and state or country) <u>DALLAS CITY, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>LOUIS A. CRANEY</u>		13b. MOTHER'S MAIDEN NAME <u>CHARLOTTE LIONBERGER</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>FRANK C. CRANEY 317 So. VAN BRUNT</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					<u>One hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial hypertension</u>					<u>10 yr</u>
DUE TO (c) <u>Congestive heart disease</u>					<u>2 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 <u> </u> Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 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 <u>August, 21, 1959</u> to <u>August, 22, 1959</u> and last saw her alive on <u>August, 22, 59</u> Death occurred at <u>Lakeside Hospital</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>V. W. Harned M.D.</u>			22b. ADDRESS <u>402 Wirthman Bldg</u>		22c. DATE SIGNED <u>8-24-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>August 25, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>
24. FUNERAL DIRECTOR ADDRESS <u>C.H. BLACKMAN & SON INC. - K. C., Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-24-59</u>	26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF V. W. Harned

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bert B. Bennett

Licensed Embalmer No. 4657

P. O. Address H. P., 7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.