

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001502

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 418 STATE FILE NUMBER

FILED VS FEB 14 1961

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> COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>29 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3309 HARRISON STREET</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3309 HARRISON STREET</b>
3. NAME OF DECEASED (Type or print) First <b>HANSEN</b> Middle <b>ALLEN</b> Last <b>McCRACKEN</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>24</b> Year <b>1961</b>	

5. SEX <b>MALE</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>9/9/1862</b>	9. AGE (last birthday) <b>98</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>SMITHVILLE, MISSOURI, U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>

13a. FATHER'S NAME <b>FRANK McCRACKEN</b>		13b. MOTHER'S MAIDEN NAME <b>MARGARET JACKSON</b>		14. NAME OF HUSBAND/OR WIFE <b>MRS. BETTY McCRACKEN</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>NONE</b>		17. INFORMANT <b>DR. S. R. McCRACKEN</b>	

Address **810 St. Louis Excelsior Springs MO.**

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>Cordae Exhaustion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>death system died in her sleep</b>
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (c) <b>arterio sclerosis</b>	

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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input checked="" 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
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on **Jan 22 - 1961**  
Death occurred at **5:00 A.** \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>R. M. Cracken M.D.</b>	(Degree or title)	22b. ADDRESS <b>Excelsior Springs Mo</b>	22c. DATE SIGNED <b>1-24-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 26, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I. O. O. F. CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>SMITHVILLE MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS</b>	ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO</b>	25. DATE RECD. BY LOCAL REG. <b>1-26-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 R. M. Cracken  
 S. O. SHOULD READ  
 ITEM NO.

**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

*Harold Z. Eckert*

Licensed Embalmer No. 3035

P. O. Address 21st Street

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.

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