

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

19428

**1. PLACE OF DEATH**

County Johnson  
Township Wheat  
City Kansas City (No. Kansas City Gen Hosp)

Registration District No. 399  
Primary Registration District No. 10

File No. 2432  
Registered No. 2432  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Carl Crawford

(a) Residence No. 162 U.E. 8th St., 9 Ward.

Length of residence in city or town where death occurred 4 yrs. 9 mos. 9 ds. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3. SEX</b> <u>male</u>	<b>4. COLOR OR RACE</b> <u>white</u>	<b>5. SINGLE, MARRIED, WIDOWED OR DIVORCED</b> (write the word) <u>single</u>		
<b>5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF</b>				
<b>6. DATE OF BIRTH (MONTH, DAY AND YEAR)</b> <u>Sept 5 1865</u>				
<b>7. AGE</b>	<b>YEARS</b> <u>64</u>	<b>MONTHS</b> <u>9</u>	<b>DAYS</b> <u>4</u>	<b>IF LESS than 1 day,</b> _____ hrs. or _____ min.
<b>8. OCCUPATION OF DECEASED</b>				
(a) Trade, profession, or particular kind of work <u>Janitor</u>				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 6-9 1930

**17. I HEREBY CERTIFY, That I attended deceased from** \_\_\_\_\_ **19** 30 **and that I last saw him alive on** 6-9 1930 **and that death occurred, on the date stated above, at** 8:15 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Hypertrophy and dilata-  
tion of heart

**CONTRIBUTORY (SECONDARY)** Edema of lungs

**18. WHERE WAS DISEASE CONTRACTED** \_\_\_\_\_  
**IF NOT AT PLACE OF DEATH** \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH?** \_\_\_\_\_ **DATE OF** \_\_\_\_\_

**20. WAS THERE AN AUTOPSY?** yes

**WHAT TEST CONFIRMED DIAGNOSIS?** Clinical + Autopsy  
(Signed) P. E. Williams, M. D.  
6-10, 1930 (Address) 54th St. K.C. Gen. Hosp

**9. BIRTHPLACE (CITY OR TOWN)** Iowa  
(STATE OR COUNTRY)

**10. NAME OF FATHER** G. W. Crawford

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** Pa  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER** Seeleie Welles

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** New York  
(STATE OR COUNTRY)

**14. INFORMANT** Reverend Clerk  
(Address) K.C. Gen. Hosp 720 Mo

**15. FILED** 9/10 **19** 30 **REGISTERAR** M. M. Crowe  
Asst

**\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.**

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Hampton **DATE OF BURIAL** 9/10 1930

**20. UNDERTAKER** W. M. East **ADDRESS** 15 East 15

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

23  
2

