

JAN 13 1940

Registration District No. 399

Primary Registration District No. 1002

State File No. _____

Registrar's No. 4623

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Marion Foster Crawford 1/16

3. (b) If veteran, name war _____ 3. (c) Social Security No. 486-05-5389

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Beatrice Crawford 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Sept. 7 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 2 28 hr. min.

9. Birthplace Kansas City Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Moving picture operator

11. Industry or business Uptown Theater

MOTHER FATHER { 12. Name James A. Crawford

13. Birthplace Mexico, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Frances Grigsby

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Beatrice Crawford

(b) Address 3920 Terrace

17. (a) Burial (b) Date thereof 12/7/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mexico, Missouri

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3811 Broadway

19. (a) Dec. 5, 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri / (b) County County
(c) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 3920 Terrace
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5th
year 1939 hour 4:20 A. M. minute _____ M.

21. I hereby certify that I attended the deceased from Dec 1, 39
_____ 19, to Dec 5 1939
that I last saw him alive on Dec 4 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor Duration _____

Due to Cerebral hemorrhage

Due to Hypertension

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy Brain tumor Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Merwin J. Kumpel (M. D. or other) _____
Address Blaga Med Bldg 150 Mo Date signed Dec 5, 39

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.

*Dr. Russell
Ploger Medical Bldg
315-Alameda Road*

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

Ralph E Miller

Registered Apprentice No. *164*

working under my personal supervision.

Signed

Joseph Hecker

Licensed Embalmer No. *3738*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson
(b) Township Kear
(c) City Keokuk Mo

Registration District No. 399
Primary Registration District No. 100

Registered No. 4623

(d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Marion Ester Crawford

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 5, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____hra. or _____min.

49

Broken tumor malignant

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation _____ Date of _____

13. NAME

What test confirmed diagnosis? _____ Was there an autopsy? _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:

15. MAIDEN NAME

Accident, suicide, or homicide? _____ Date of injury _____, 19____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? _____ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury _____

PLACE _____ DATE _____, 19____

Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____

20. FILED Dec 5, 1939 M. H. Browne
Local Registrar.

If so, specify _____ (Signed) _____, M. D.

(Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S. 42214