

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

FILED FEB 26 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1045

Registrar's No. 30

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County. Jackson
(b) City or town. Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community twenty five years years, months or days)

3. (a) PRINT FULL NAME Clarence Cripps 612

3. (b) If veteran, name war unknown 3. (c) Social Security No. unknown

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased 1880 Date Unknown
(Month) (Day) (Year)

8. AGE: Years 60 Months Days If less than one day
hr. min.

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

10. Usual occupation Power for Standard Laundry Co

11. Industry or business Standard Laundry Co

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant's own signature A. M. Perry

(b) Address 2315 Linwood Blvd

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director W. F. Mayberry

(b) Address 2315 Linwood Blvd

19. (a) Jan. 4, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Jackson
(c) City or town. Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1010 E. 12th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2nd
year 1940 hour 1 minute 40 A.M. M.

21. I hereby certify that I attended the deceased from 12-31-
1939 to 1-2-40, 19____;
that I last saw him alive on 1-2-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation
Due to 9:50

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy None

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 Dr. DeLiana M.D. (M. D. or other)
Address Supt. K.C. Gen. Hospital Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 THE

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Ray E. Sauer

Licensed Embalmer No. 7560

P. O. Address 1507 E 29

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1045-
Registrar's No. 30

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 399

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community years, months or days (Specify whether)

3. (a) PRINT FULL NAME Clarence Cripps
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex m Color or race w
5. Color or race w
6. (a) Single, widowed, married, divorced, wid

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive

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

8. AGE: Years 60 Months Days If less than one day

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address 1-4-40

19. (a) (Date received local registrar) (b) M. M. Gowen (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH Month Jan day 2 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death
Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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 P. T. De Maria D. or other Address St. Paul Hosp. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

