S. No. 2
4-13-40
5-17-39
PI X23159

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24181

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2791

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

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: Trinity Hospital, K.C.Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 14 Years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 7706 Indiana, Avenue, K.C.Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Jeff Arnold Criner, 656

3. (b) If veteran, name war None

3. (c) Social Security No. 495-01-3059

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ----------

6. (c) Age of husband or wife if alive ------ years

7. Birth date of deceased June 5th, 1905 (Month) (Day) (Year)

8. AGE: Years 35 Months 1 Days 5 If less than one day ____ hr. ____ min.

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

10. Usual occupation Bakery Salesman

11. Industry or business ---------

FATHER
12. Name John M. Criner,
13. Birthplace Arkansas (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Eliz. Cooper,
15. Birthplace Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eliz. Criner,
(b) Address 7706 Indiana, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11th, 40 (Month) (Day) (Year)
(c) Place: burial or cremation shipped to- Harrison, Arkansas.

18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918 Brooklyn Avenue, K.C.Mo.

19. (a) July 11, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th, year 1940 hour ____ minute ____ P.M.

21. I hereby certify that I attended the deceased from July 7/40 July 10, 1940 to ____, 19____; that I last saw him alive on July 10/40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Duodenal Ulcer Perforation & Peri-tonitis 1 D 11 Hr

Due to ____

Due to ____

Other conditions (Include pregnancy within 3 months of death)

Duration

Major findings: Of operations General Peritonitis due to Perforated Ulcer

Of autopsy ____

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

23. Signature John Ogle (M.D.) (M. D. or other)
Address City Date signed

(Licensed Embalmer's Statement on Reverse Side)

Aug 28 - 72 2443
1:30 P.M. - 5 P.M.

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

Signed C H Meise

Licensed Embalmer No. 25-70

P. O. Address 1C Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.