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.

OCT 11 1940

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

31182
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Law — Primary Registration District No. 1002 — Registered No. 3745
(c) City Kansas City — (d) Street No. St. Vincent's Hosp. St.
(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 Mary Patricia Crockett
(a) Residence, No. Kansas City, Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26/40
7. AGE YEARS ✓ MONTHS ✓ DAYS ✓ If LESS than 1 day ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
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 ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

FATHER
13. NAME Joseph E. Crockett
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Liberty Mo

MOTHER
15. MAIDEN NAME Margaret McEnaney
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Corning Kans

17. INFORMANT (ADDRESS) Joseph Crockett 2409 Indiana
18. BURIAL, CREMATION, OR REMOVAL
PLACE St Mary DATE Sept 28, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Family
20. FILED 9-27-40, 19 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 27, 1940
22. I HEREBY CERTIFY, That I attended deceased from 9 59 PM 9/26/40 9/27/40, 19
I last saw her alive on 9/26/40 10, 19 Death is said to have occurred on the date stated above, at 7 a m.
The principal cause of death and related causes of importance were as follows:

Respiratory forsoye Blocked with heavy mucus.

158.

Date of onset

Other contributory causes of importance:

Name of operation None Date of
What test confirmed diagnosis? Clinical. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury No
Nature of injury No

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Joseph A. Nuttle, M. D.
(Address) 1103 Grand.

(Licensed Embalmer's Statement on Reverse Side)

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....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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