

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2924

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:  
3516 Summit /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 42 years (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Lola Lawing Crawford

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 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 \_\_\_\_\_ years

7. Birth date of deceased August 9, 1863  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>11</u>	<u>22</u>	hr. min.

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

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

12. Name William A. Lawing

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

14. Maiden name Angeline Weaver

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

16. (a) Informant Tom R. Crawford

(b) Address 7410 Wyoming

17. (a) Burial (b) Date thereof 8-4-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 West 42nd Street

19. (a) 8/2/41 (b) M. M. Brown  
(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. 3516 Summit  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1st  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M

21. I hereby certify that I attended the deceased from 18 1935 to Aug 11 1944  
that I last saw her alive on Aug 6 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Myocarditis

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 M. M. Brown (M. D. or other) \_\_\_\_\_  
Address 636 W. 4th St. Date signed 8/2/41

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

MOTHER FATHER

AUG 22 1940

to file in  
period 7. 2. 2. 2. 2. 2.

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 *Clarence H. Childs*

Licensed Embalmer No. *3473*

P. O. Address *76 E 760*

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, fact should be so stated above.

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