

FILLED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33835**  
Registrar's No. **3770**

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: **Trinity Lutheran**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 days**  
In this community **Non Resident** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mrs. Mary C. Crawford**

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

4. Sex **Fe** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Joseph H. Crawford** 6. (c) Age of husband or wife if alive **XX** years  
7. Birth date of deceased **Nov. 7 1851**  
(Month) (Day) (Year)

8. AGE: Years **89** Months **11** Days **2** If less than one day hr. min.

9. Birthplace **Preble Cty Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

MOTHER { 12. Name **Joseph Sheller**  
13. Birthplace **No Record**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Margaret Schneider**  
15. Birthplace **No Record**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Chester A. Crawford**  
(b) Address **1440 E. 78th St. K.C. Mo.**  
17. (a) **Removal** (b) Date thereof **10-10-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Creighton, Mo.**

18. (a) Signature of funeral director **J. Wagner**  
(b) Address **Kansas City, Mo.**  
19. (a) **10/9/41** (b) **M. M. Crow**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cass**  
(c) City or town **Creighton**  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **9th**  
year **1941** hour **11** minute **20 P. M.**

21. I hereby certify that I attended the deceased from **Sept 29 - 1941 to Oct 9 - 1941**  
that I last saw him alive on **Oct 9 - 1941**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration   
Due to **11/2**  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **Ho** Of autopsy **See above** 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?

While at work? (Specify type of place) (e) Means of injury  
23. Signature **J. M. [unclear]** (M. D. or other) **10/9/41**  
Address **3859 Brooklyn** Date signed **10/9/41**

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

*L.S. M. o. Calman*  
*3850 App. Klym*

**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 *Cecil R. Matthes*  
Licensed Embalmer No. *3807*  
P. O. Address *Kansas City, 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, fact should be so stated above.**