

S. No. 2
1-9-4-41
5-17-39
VI X2948A

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29384**
Registrar's No. **3461**

FILED OCT 5 1942

Registration District No. **149** 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 **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 hrs.**
In this community **4 Hours**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Independence Missouri**
(If outside city or town limits, write "RURAL")
(d) Street No. **418 S. Forest.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **John Fraccis CRICK.**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September** day **20th**
year **1942** hour **11** minute **15 P.M.**

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 **Sept. 20th, 1942**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **birth 7th**, 19____ to **11:15 AM, 1942**
that I last saw him alive on **Sept 20**, 1942, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
4 hr. **30** min.

Immediate cause of death **premature delivery 7 1/2 mo. gestation**
Due to _____
Due to _____

9. Birthplace **Kansas City Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Infant**

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy **none**

MOTHER FATHER
11. Industry or business _____
12. Name **Leonard Crick**
13. Birthplace **Lincoln Nebraska**
(City, town, or county) (State or foreign country)
14. Maiden name **Marie Trumble**
15. Birthplace **Eagle Nebraska**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Leonard Crick.**
(b) Address **418 S. Forest, Indep. Mo.**
17. (a) **Burial** (b) Date thereof **9/21/42**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Marys.**
18. (a) Signature of funeral director **Melody-McGilley**
(b) Address **K. C. Mo.**
19. (a) **9/21/42** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

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)
23. Signature **Edwin C. ...** (M. D. or other) _____
Address **1032 ...** Date signed **9/21/42**

DR. WHITE
PROF. BLOG
2 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.....
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 comply with the above constitutes grounds for revocation of license.)

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