

FILED AUG 6 1943 149

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 3056

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:  
314 N. Wheeling /  
(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 49 years  
(Specify whether years, months or days)

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. 314 N Wheeling  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Ida R. Crum

3. (b) If veteran, name war -- no

3. (c) Social Security No. none

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife George E. Crum

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

7. Birth date of deceased Jan. 31, 1876  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>5</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Robert E. Gibbons

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

14. Maiden name Mary Alice Johnson

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

16. (a) Informant Mrs. Lillian B. Miller

(b) Address 314 N. Wheeling, K.C. Mo.

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof 7-14-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cemetery

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6806 Indep. Ave. K.C. Mo.

19. (a) 7-12-43  
(Date received local registrar)

(b) T. E. Brown  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12  
year 1943 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from July 3, 1943 to July 11, 1943  
that I last saw her alive on July 11, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Decompensated myocarditis 2 days  
Cholecystectomy with approx. fistulous drainage.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 12 7 1/2  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature J. J. Fozzik (Mr., Dr. or other) Dr.

Address 5902 St. John Date signed 7/12/43

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

MOTHER FATHER

Dr. J. J. Postak

5902 St John , Ch 4062

---

---

**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.**