

FILED AUG 13 1943

Registration District No. **149**

Primary Registration District No. **0569**

Registrar's No. **127**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City**
 (c) Name of hospital or institution: **7215 Sycamore**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **NO.**
 In this community **50 years**
 (Specify whether years, months or days)

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. **7215 Sycamore**
 (If rural, give location)
 (e) Citizen of foreign country? **X** (Yes or No)
 If yes, name country **X**

3. (a) PRINT FULL NAME **Charles C. Craver**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

4. Sex **Male** 5. Color or Race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Leota Craver** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **February 2 1859**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 4 28 hr. min.

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

10. Usual occupation **Retired**

11. Industry or business **X**

12. Name **FATHER**

13. Birthplace **9** (City, town, or county) (State or foreign country)

14. Maiden name **MOTHER**

15. Birthplace **9** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Leota Craver**

(b) Address **7215 Sycamore, Kansas City, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-2-43**
 (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, Kansas City, Mo.**

19. (a) **July 2-43** (Date received local registrar) (b) **Miss E. Larwin** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **30th**
 year **1943** hour **1:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **Oct 1942** to **Jan 29 1943**
 that I last saw **in** alive on **Jan 29 1943**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Atherosclerosis**
 Due to **hypertensive chronic**

Due to **930**
 Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **930**
 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) (c) Means of injury _____

23. Signature **[Signature]** (M. D. or other)
 Address **[Address]** Date signed **7/1/43**

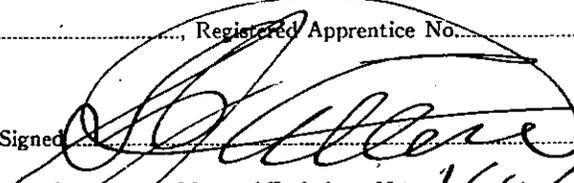
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

For Emil Schultz
P.O. # 1364
No. 3600

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. 1415
P. O. Address 159 W. D. St.

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.

AUG 13 1943

State File No. _____

Registration District No. 127

Primary Registration District No. 0369

Registrar's No. 127

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town RURAL - BROOKING TWP
(If outside the city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(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 _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 _____

3. (a) PRINT FULL NAME Charles C. Craver

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MA 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 2
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 13 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

93-219129