

FILED JUN 7 1946

Registration District No. 73

Primary Registration District No. 5-2-91

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Liberty Liberty Twp.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Rural Route 3 Liberty
(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 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clay 24
 (c) City or town Liberty 0
(If outside city or town limits, write "RURAL")
 (d) Street No. RR 2 0
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country No

3. (a) PRINT FULL NAME Isabele Crouse

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

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

6. (b) Name of husband or wife Frank Crouse 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased June 11 1869
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 4 If less than one day _____
hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Johnson 9

13. Birthplace Unknown (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (State or foreign country)

16. (a) Informant Martin Crouse

(b) Address RR 3 Liberty

17. (a) Burial (b) Date thereof 5/17/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Liberty

18. (a) Signature of funeral director [Signature]

(b) Address 119 E Franklin St. Liberty, Mo.

19. (a) May 17 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
 year 1946 hour 5 minute 40 AM

21. I hereby certify that I attended the deceased from Sept 1937 to May 15 1946;
 that I last saw her alive on May 14 1946;
 and that death occurred on the date and hour stated above.

Immediate cause of death Fracture left hip 5 days
Duration

Due to Fall from step on porch

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 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 0

23. Signature Glen W. Hurdent M. D. or other MD

Address Liberty, Mo. Date signed 5/18/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 6-5-46

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. 3934

P. O. Address Liberty, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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

Registration District No. 73

Primary Registration District No. 5291

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Liberty Twp
 (If outside 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 _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME Isabelle Crouse

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

4. Sex F 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 _____

7. Birth date of deceased June 11 1862
 (Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Mo
 (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1946 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____, 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 _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident ✓

(b) Date of occurrence May 10, 1946 ✓

(c) Where did injury occur? Liberty Bery R.R. Mo ✓
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes from back porch at home ✓

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Glen W. Henderson (M. D. or other) ✓
Liberty, Mo Date signed 6/11/46

Address _____

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

14963

WRITE PLAINLY IN INK TAKE A FEW MIN.

160071