S. No. 2
M—5-43
5-17-39
1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30541

FILED SEP 17 1946

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 285

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Independence
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1205 N. McCoy
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: - - -
In this community: 38 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Independence 4
(If outside city or town limits, write "RURAL")

(d) Street No.: 1205 - N. McCoy street 4
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 3

If yes, name country: - - - -

3. (a) PRINT FULL NAME: O. DEAN CROW

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male O

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Lillie Crow

6. (c) Age of husband or wife if alive: 55 years

7. Birth date of deceased: May (Month) 20 (Day) 1874 (Year)

8. AGE: Years 72 Months 2 Days 27 If less than one day: - hr. - min.

9. Birthplace: Clay County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: A. T. Crow
13. Birthplace: Unknown (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Sarah Creek
15. Birthplace: Unknown (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant: Mrs. Lillie Crow
(b) Address: 1205 - N. McCoy

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: August 20, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn Cemetery

18. (a) Signature of funeral director: George E. Carson
(b) Address: Independence, Missouri

19. (a) 8-30-46 (Date received local registrar) (b) [signature] (Registrar's signature)

354 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17 year 1946 hour 8 minute M.

21. I hereby certify that I attended the deceased from Dec 1945 to Aug 17 1946 that I last saw him alive on Aug 17 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sepsis	months
Due to: Pyelitis + chronic cystitis	2 yrs
Due to: Hypertrophy prostate	chronic
Other conditions (Include pregnancy within 3 months of death): Valv Heart Disease	chronic

Major findings:
Of operations:
Of autopsy: 92D

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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: J. C. Heckerson (M. D. ~~or other~~)
Address: Independence Mo Date signed: Aug 18 1946

JUL 1 9 1948

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 Raymond M Martin

Licensed Embalmer No. 4150

P. O. Address Indep. 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.