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U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1947
Registration District No. 197

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4788**
Registrar's No. **602**

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
604 west 33rd. St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
In this community 10 yrs.
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Jackson H. Cromwell
3. (b) If veteran, name war none
3. (c) Social Security No. 486-01-2994

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife Edith Cromwell
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 7 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>3</u>	<u>2</u>	hr. min.

9. Birthplace Olathe Kans. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Sellers Marquis Roofing Co.

MOTHER FATHER
12. Name Douglas Cromwell
13. Birthplace Olathe Kans 1
(City, town, or county) (State or foreign country)
14. Maiden name Aliza Kennick
15. Birthplace St Josephs Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant J. H. Cromwell Jr.

(b) Address New York, City

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47
(Month) (Day) (Year)

(c) Place: burial or cremation Olathe Cem. Olathe

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

(b) Address Kansas City, Kans.

19. (a) 2-10-47 (Date received local registrar) Aleraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 604 west 33rd. st.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3 year 1947 hour 3:00 minute 35P M.
21. I hereby certify that I attended the deceased from Jan 12 47 to Feb 9 47 and that I last saw him alive on Feb 9 47 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to _____
Due to _____

Other conditions Bronchogenic Carcinoma
(Including pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 47C

Duration _____
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) no
(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? no
While at work? ✓ (Specify type of place) (e) Means of injury ✓
23. Signature M F Jewell (M. D. or other) M.D.
Address 1722 W 39th Date signed _____

2412

3981501

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.