FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 1 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 4783

Registrar's No. 282

WRITE PLAINLY—USING 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: St. Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 6 days (Specify whether years, months or days)

In this community: 23 years

**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.: 2942 Wabash (If rural, give location)

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

If yes, name country:

**3. (a) PRINT FULL NAME:** ARTHUR B. CRAIN

3. (b) If veteran, name war: xx no

3. (c) Social Security No.: 495-03-5408

4. Sex: Ma

5. Color or race: Wh

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

6. (b) Name of husband or wife: Gladys B. Crain

6. (c) Age of husband or wife if alive: 57 years

7. Birth date of deceased: April (Month) 25 (Day) 1891 (Year)

8. AGE: Years 56 | Months 9 | Days 25 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: Pharmacist

11. Industry or business:

FATHER
12. Name: Isaac H. Crain
13. Birthplace: Logansport, (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name: Martha Lyford
15. Birthplace: Brunswick (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Gladys B. Crain

(b) Address: 2942 Wabash

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-22-48 (Month) (Day) (Year)

(c) Place: burial or cremation: Floral Hills

18. (a) Signature of funeral director: J W Wagner

(b) Address: Kansas City, Mo.

19. (a) 2-21-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 20 year 1948 hour 11 minute 00 A.M.

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

Immediate cause of death: Acute Toxic Hepatitis

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): 125 N

Major findings: Of operations:

Of autopsy: above

Duration

PHYSICIAN

Underline the cause of 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:

23. Signature: [signature] (M.D. or other)

Address: St Joseph Hospital Date signed: 20 Feb 48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

## 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 Alvin R. Hauschild

Licensed Embalmer No. 4159

P. O. Address Kansas City M

**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.**