

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

1261

State File No. \_\_\_\_\_

FILED JAN 27 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1

<b>I. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>JACKSON</u>		a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. LENGTH OF STAY (in this place) <u>8 days</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2719 CHELSIA</u>		e. STREET ADDRESS (If rural, give location) <u>35 2719-CHELSIA</u>	
<b>3. NAME OF DECEASED</b>		<b>4. DATE OF DEATH</b>	
a. (First) <u>ELLA</u>		(Month) (Day) (Year)	
b. (Middle) <u>D</u>		<u>1 1 54</u>	
c. (Last) <u>CRIFE</u>			
<b>5. SEX</b> <u>1</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>	
<u>FEMALE</u>		<u>WHITE</u>	
<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <u>2</u>		<b>8. DATE OF BIRTH</b> <u>June 16, 1895</u>	
<u>WIDOWED</u>		<u>78</u>	
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>9b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u>	
		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>MISSOURI</u>	
<b>13a. FATHER'S NAME</b> <u>JAMES PERRIN</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH DAVIS</u>	
		<b>14. NAME OF HUSBAND OR WIFE</b> <u>BURTH C. CRIFE</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Miss Constance J. Kasper</u>	
		<b>ADDRESS</b> <u>424 So Denver</u>	
<b>18. CAUSE OF DEATH</b>		<b>MEDICAL CERTIFICATION</b>	
Enter only one cause per line for (a), (b), and (c)		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cerebral thrombosis, left internal capsule</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<b>ANTECEDENT CAUSES</b>	
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	
		DUE TO (b) _____	
		DUE TO (c) _____	
		<b>II. OTHER SIGNIFICANT CONDITIONS</b> <u>Bronchial asthma</u>	
		Conditions contributing to the death but not related to the disease or condition causing death.	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b>			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b>	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>1-30, 1951</u> , to <u>1-1, 1954</u> , that I last saw the deceased alive on <u>12-27, 1953</u> , and that death occurred at <u>12:48 a.m.</u> , from the causes and on the date stated above.			
<b>23a. SIGNATURE</b> <u>Richard W. Gunn</u>		<b>23b. ADDRESS</b> <u>6230 Fremont Rd. Ke. Fe, Mo.</u>	
(Degree or title) <u>M.D.</u>			
		<b>23c. DATE SIGNED</b> <u>1-1-54</u>	
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24b. DATE</b> <u>Jan 2-54</u>	
		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Washington</u>	
		<b>24d. LOCATION</b> (City, town, or county) (State) <u>Kansas City, Mo.</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>1-1-54</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Geraldine Smith</u>	
		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Sheil Funeral Home</u>	
		<b>ADDRESS</b> <u>Ke. Fe, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

*312*

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**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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. *36*

P. O. Address *K.C. Mo.*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING.  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.