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FILED MAR 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8157**

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar No. **973**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Kansas b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 15 Mo.		d. STREET ADDRESS (If rural, give location) 137 So. 16 st.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

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3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Lewis c. (Last) Crookham			4. DATE OF DEATH (Month) (Day) (Year) March 2, 1955		
5. SEX D Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 5, 1883	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Switchman		10b. KIND OF BUSINESS OR INDUSTRY Frisco R. R.		11. BIRTHPLACE (State or foreign country) Leon, West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Smith Snell Crookham		13b. MOTHER'S MAIDEN NAME Mary Matilda Williams		14. NAME OF HUSBAND OR WIFE Elizabeth Frances Crookham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Maxine Gossage K.C.Ks.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bed fast - DUE TO (c) Cerebral vascular accident II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure			INTERVAL BETWEEN ONSET AND DEATH 4 months
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from **Feb 1, 1955**, to **MAR 2, 1955**, that I last saw the deceased alive on **MARCH 2, 1955**, and that death occurred at **9:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE R. L. Shireman (Degree or title) M.D.		23b. ADDRESS 4126 St. John Ave K.C. Mo.		23c. DATE SIGNED MAR 4 1955	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 3-4-1955		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		24d. LOCATION (City, town, or county) (State) Kansas City, Kansas	
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DATE REC'D BY LOCAL REG. 3-4-55		REGISTRAR'S SIGNATURE Neve Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Floral Hills Chapel K.C.Ks.	
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

Dr 02550

Dr. Ross Blanford

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 _____
Student Embalmer

Signed *Dr. Ross Blanford*

Licensed Embalmer No. *4015*

P. O. Address *K C 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.