

FILED SEP 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30648

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3872

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>KANSAS CITY 0</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				c. CITY OR TOWN <u>KANSAS CITY 0</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKE'S HOSPITAL</u>				Length of stay in 1b <u>4 1/2 yrs</u>		d. STREET (If outside, give location) ADDRESS <u>4001 MONTGALL AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>NED</u> Middle <u></u> Last <u>CRANE</u>				4. DATE OF DEATH <u>SEPT-1-1956</u> Month <u>SEPT</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN-1-1909</u>	
9. AGE (In years last birthday) <u>47</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER-Pipefitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DARBY CORPORATION</u>		11. BIRTHPLACE (City and state or country) <u>OTTAWA KANSAS</u>	
13. FATHER'S NAME <u>CHARLES E. CRANE</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE LYONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>486-01-1430</u>		17. INFORMANT <u>MRS. VELTA CRANE</u> Address <u>4001-MONTGALL AVE. KANSAS CITY MO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Head Injury</u> DUE TO (c) <u>Cerebral Contusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6<sup>02</sup>50</u> <u>33</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>123</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Thrown from Truck load of pipe</u>	
20c. TIME OF INJURY Hour <u>5:30</u> Month <u>Aug</u> Day <u>29</u> Year <u>56</u> p. m. <u>AM</u>							
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Welding house plant</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>		COUNTY <u>Jackson mo.</u> STATE	
21. I attended the deceased from <u>29 Aug - 56</u> , to <u>1 Sept - 56</u> and last saw her/him <u>live on 31 Aug - 56</u> ✓ Death occurred at <u>5:30 A. M.</u> on the date stated above; and to the best of my knowledge, from the cause stated.							
22a. SIGNATURE <u>H. Carmichael M.D.</u>				22b. ADDRESS <u>411 Nichols Rd</u>		22c. DATE SIGNED <u>1 Sept 56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>SEPT-4-1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
24. FUNERAL DIRECTOR <u>DW. NEWCOMER'S SONS</u> ADDRESS <u>KANSAS CITY, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>9-4-56</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minchell</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56All  
symptoms  
will be listed.  
All  
diseases in Part I must be causally related.  
Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Je 1-3303-

22-1-1911  
J. C. [unclear]

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..... Basil Stone

Licensed Embalmer No. 417

P. O. Address R. C. [unclear]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.