

FILED JUN 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17010
STATE FILE NUMBER
2278

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

S. 300
1-57

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5403 Montgall		Length of stay in lb 45 yrs.	d. STREET ADDRESS 5403 Montgall (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CARL CRUTCHFIELD			4. DATE OF DEATH Month May Day 16 Year 1957		
5. SEX 2 Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1887	9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) Malta Bend, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Cubit Crutchfield		13b. MOTHER'S MAIDEN NAME Winnie Jackson		14. NAME OF HUSBAND OR WIFE Luella Crutchfield	
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. None		17. INFORMANT Address Luella Crutchfield, wife 5403 Montgall	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leucinaemia of throat, + mitral insufficiency. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (a) DUE TO (c) mitral insufficiency. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) mitral insufficiency.					INTERVAL BETWEEN ONSET AND DEATH 148+
20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-17-57 to 5-16-57 and last saw him alive on 5/16/57 . Death occurred at 5403 Montgall on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Henry B. Lyons, M.D.			22b. ADDRESS 1605 East 18th		22c. DATE SIGNED 5/17/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-20-57	23c. NAME OF CEMETERY OR CREMATORY Highland		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Watkins Bros. Fn. Hm. 18th & Benton			25. DATE RECD. BY LOCAL REG. 5-17-57	26. REGISTRAR'S SIGNATURE newa munsell	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Henry B. Lyons

JUN 28 1957



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 *Bruce R. Watkins*

Licensed Embalmer No. *450*
P. O. Address *18th Beuten*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.