

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 28 1959

59-028455

STATE FILE NUMBER

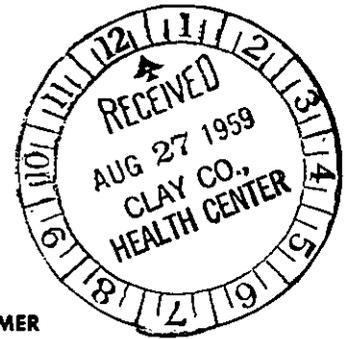
Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 79

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Clay</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> Length of stay in 1b <u>47 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>510 Isley</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Robert</u> Last <u>Crenshaw</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>5</u> Year <u>1959</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-21-1877</u>	<b>9. AGE (last birthday)</b> <u>82</u>	<b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u>	<b>IF UNDER 24 HR</b> Hours <u>    </u> Min. <u>    </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Oil Sta. Operator</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>    </u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Knoxville, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Granville Crenshaw</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mattie Thompson</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Martha Frances Thomson</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>492-38-4717</u>		<b>17. INFORMANT</b> Address <u>Mrs Martha Crenshaw, Excelsior Springs, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>&amp; paralysis of chest &amp; throat</u> DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>    </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>    </u> a.m. <u>    </u> p.m. Month, Day, Year <u>    </u>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21.</b> I attended the deceased from <u>9-26-52</u> to <u>8-5-59</u> and last saw him alive on <u>8-5-59</u> Death occurred at <u>11:45 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>George E Sanders M.D.</u>				<b>22b. ADDRESS</b> <u>Excelsior Springs, Mo.</u>		<b>22c. DATE SIGNED</b> <u>8-7-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>8-7-1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lawson</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Lawson Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Richard Tunst Home, Excelsior Springs, Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-21-59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Carolene Hutchings</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF



**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ralph Van Landingham

Licensed Embalmer No. 4009  
P.O. Address Galena Springs,

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