

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048681

FILED VS JAN 23 1961

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6483 STATE FILE NUMBER

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 MO	Length of stay in 13 ^{months}	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 St. Lukes Hospital		d. STREET ADDRESS (if outside, give location) 20 west 26th - 415 apt.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Nell Middle - Last Crouch			4. DATE OF DEATH Month 12 Day 25 Year 60	
5. SEX F	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1873	9. AGE (last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Reg. Nurse		10b. KIND OF BUSINESS OR INDUSTRY U.S. Military	11. BIRTHPLACE (City and state or country) Carroll Co. MO	12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME William S Crouch	13b. MOTHER'S MAIDEN NAME Nell Melvina Daniels	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW1	16. SOCIAL SECURITY NO. 488-52-8966	17. INFORMANT Mrs BAKER BROWNING	Address Carrollton MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Congestive heart failure		3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis and myocardial ischemia	2 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) Surgery for small intestinal obstruction due adhesions performed Dec 12, 1960; Multiple abscesses of kidneys and prostate unclassified.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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.) no
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input 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.)	20f. CITY, TOWN, OR LOCATION Carrollton	COUNTY Missouri	STATE
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21. I attended the deceased from **Dec 1, 1960** to **Dec 25, 1960** and last saw her/him alive on **Dec 25, 1960**
Death occurred at **11:55 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William F. Sanders M.D.	22b. ADDRESS 411 Nichols Rd Kansas City, Mo	22c. DATE SIGNED 12/25/60.
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-25-1960	23c. NAME OF CEMETERY OR CREMATORY Outhill Cemetery	23d. LOCATION (City, town, or county) (State) Carrollton, Missouri
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24. FUNERAL DIRECTOR Gibson Funeral Home	ADDRESS Carrollton Missouri	25. DATE RECD. BY LOCAL REG. 12-26-60	26. REGISTRAR'S SIGNATURE H-L. Dwyer
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DOCUMENT

BY AFFIDAVIT OF WILLIAM F. SANDERS MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ben W Gibson

Licensed Embalmer No. 29
P. O. Address Carrollton

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