

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-008720

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1435

AMENDED

FILED APR 6 1961

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>7 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1919 1/2 Main St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Corb</b> Middle <b>Ray</b> Last <b>Cruickshank</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>19,</b> Year <b>1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-17-1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Terminal Clerk, Postal Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hallowell, Kansas</b>	9. AGE (last birthday) <b>52</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
13a. FATHER'S NAME <b>George Cruickshank</b>		13b. MOTHER'S MAIDEN NAME <b>Florence Fee</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b> 14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Mrs. Lola Beggs, Columbus, Kan.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Palvic Phlebotrombosis</b>			<b>10 days</b>
DUE TO (c) <b>Complete Bed rest</b>			<b>16 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Rotated retina, op</b>			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
19. WAS AUTOPSY PERFORMED? YES <input 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.)	
20c. TIME OF INJURY Hour 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	COUNTY STATE
21. I attended the deceased from <b>3-9-61</b> to <b>3-19-61</b> and last saw him alive on <b>3-19-61</b> Death occurred at <b>12:55</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Charles S. Cooper</b> (Degree or title)		22b. ADDRESS <b>618 Poplarwood Bldg</b>	22c. DATE SIGNED <b>3/21/61</b> (Staff)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-20-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>McKee Cemetery</b>
24. FUNERAL DIRECTOR <b>Stine &amp; McClure, Kansas City, Mo.</b>		23d. LOCATION (City, town, or county) <b>Columbus, Kansas</b>	
25. DATE RECD. BY LOCAL REG. <b>3-21-61</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

ITEM NO. SHOULD READ INSTEAD OF DATE AMENDED

BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

Charles S. Cooper

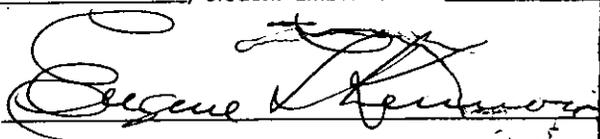
Cooper  
618 Prof Bldg  
134-1-2032  
11:00

**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  \_\_\_\_\_

Licensed Embalmer No. 4653

P. O. Address Kansas City

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.