

FILED AUG 2 1944  
Registration District No. 149

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Cresthaven Conv. Home 3516 Summitt.  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 3 Years 4  
7 Years. (Specify whether  
In this community 7 Years.  
years, months or days)

3. (a) PRINT FULL NAME Laura Louise CRONIN

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife -Simon Pat. Cronin

6. (c) Age of husband or wife if alive \*\*\*\*\* years

7. Birth date of deceased December 11th, 1859  
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 5  
If less than one day hr. min.

9. Birthplace High Point Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Invalid at Home

MOTHER FATHER

11. Industry or business

12. Name Thomas J. Hart.

13. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Harriett Van Arsdale

15. Birthplace Pennsylvania.  
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas J. Cronin.

(b) Address 5305 Charlotte Street.

17. (a) Removal (b) Date thereof 7/17/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation California Missouri.

18. (a) Signature of funeral director Melody-McGilley

(b) Address Kansas City Mo.

19. (a) 7-17-44 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City Mo. 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 5305 Charlotte Street. 2  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th  
year 1944 hour 12 minute 09 A.M.

21. I hereby certify that I attended the deceased from Gene 1940 to 1944  
that I last saw Gene alive on July 15- 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 61

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature M. B. Peterson M.D. (M.D. or other) \_\_\_\_\_  
Address Kansas City Mo. Date signed 7-16-44

**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 \_\_\_\_\_  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

*J. D. [Signature]*  
Licensed Embalmer No. 2909

P. O. Address 150

**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 this body is not embalmed, fact should be so stated above.**