MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

20871

File No. ____
Registered No. 2753

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas City (No. Old City Hospital St. ____ Ward)
Registration District No. 399
Primary Registration District No. 1002

2. FULL NAME: James Green
(a) Residence. No. 707 Locust St., 1 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR ~~OR RACE~~: ed
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): student

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 3, 1920

7. AGE: Years 8 | Months | Days 22 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER: Louise Green
11. BIRTHPLACE OF FATHER (CITY OR TOWN): ?
(STATE OR COUNTRY): Arkansas
12. MAIDEN NAME OF MOTHER: Bertha Green
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): ?
(STATE OR COUNTRY): Arkansas

14. INFORMANT: Bertha Green
(Address): 707 Locust.

15. FILED 6/26, 1928 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6-25 1928

17. I HEREBY CERTIFY, That I attended deceased from 6-21, 1928, to 6-25, 1928 that I last saw h. alive on 6-25 1928 and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Encephalitis
Lethargica
17
(duration) 7 yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) 33
(duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ~~No~~ 707 Locust
DID AN OPERATION PRECEDE DEATH? No DATE OF ____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
6/26, 1928 (Signed) Howard M. Smith, M. D
(Address) Old City Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Blue Ridge
DATE OF BURIAL: 6-27 1928

20. UNDERTAKER: H B Moore
ADDRESS: 1820 E 18th st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.