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

Do not use this space.

1525

399

1002

115

1. PLACE OF DEATH
County: Jackson
Township: T. Raw
City: Kansas City (No. Kansas City General Hospital St. Ward)
Registration District No.
Primary Registration District No.
File No.
Registered No.

2. FULL NAME: Mrs Jean Green
(a) Residence. No. 2601 Myrtle St., 14 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.

48
10
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PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widow.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Leonidas B. Green

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 30-1866

7. AGE: Years 62 | Months 5 | Days 8 | If LESS than 1 day, ... hrs. or ... min.

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

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

PARENTS
10. NAME OF FATHER: Moore Collins
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): England
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Wm E. Wilcoxen
(Address): 3446 Askew

15. FILED 1-10, 1929 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 8 1929 Tuesday

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 6.45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY) Fract hip - Acc Fall at home
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Marion M. Allen, M. D
1/8, 1929 (Address) Deputy Coroner

*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: Cremation Elmwood
DATE OF BURIAL: Jan. 10 1929

20. UNDERTAKER: Eylar Funeral Home
ADDRESS: 1800 Linwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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