

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

Do not use this space

17976

1. PLACE OF DEATH

County Jackson
Township Blue
City Independence

Registration District No. 398
Primary Registration District No. 3019

File No.
Registered No. 186
St. Ward)

2. FULL NAME

(a) Residence 415-70 Eubank St., 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 20, 1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
6 1 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Independence
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Fred R Green

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lebanon
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Martha B. Green

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs Fred Green
(Address) 415 Eubank

15. FILED 5-13-29 7d Cook

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/12 1929

17. Dr. Spate Coroner
I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at 2:00 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

3rd Degree Burn
7181

CONTRIBUTORY (SECONDARY) Caused by electrical
Electric Theater

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) [Signature] M. D.

5/12, 1929 (Address) Independence

*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 Mound Grove DATE OF BURIAL 5-13-29

20. UNDERTAKER Call Carson & Son ADDRESS Independence

N. B.—Every item of information on this form is of vital importance in the study of the CAUSE OF DEATH in plain language.

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**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 398 File No. _____
 Township _____ Primary Registration District No. 3019 Registered No. 189
 City Independence (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 7/10/19 F. L. BOOK REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-12-1929

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

3rd degree burns
Caused by electric
water
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Caused by Electric
water (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

_____ 19____ (Address) _____

*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 _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

WRITE PAINLY, WITH UNFADING, INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully verified. It should be stated EXACTLY. PHYSICIAN should state. Cause of death should be stated in plain terms, so that it may be properly classified. Acceptance of this certificate is subject to every imperious condition of the law. RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. A FEE IS PRESCRIBED BY LAW.

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