

1939 APR 17 1939

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

9399
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township New Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. 5301 Michigan Registered No. 1005
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME
660 Mrs Mary J Green
 (a) Residence, No. 5301 Michigan St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Abraham Green
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 11, 1898
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 11 26
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. at home
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 5 1939
 22. I HEREBY CERTIFY, That I attended deceased from 3/3 1937 to 3/5 1939
 I last saw him alive on 3/5 1939 Death is said to have occurred on the date stated above, at 10:15 P.M.
 The principal cause of death and related causes of importance were as follows:
Heart bronchial pneumonia
 Date of onset 3/1/39
 Other contributory causes of importance Chronic interstitial nephritis, chronic myocarditis
 Name of operation _____ Date of _____
 What test confirmed diagnosis staining Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. W. Haebber M. D.
5301 Michigan (Address)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henry City Ohio
 13. NAME unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 17. INFORMANT (ADDRESS) Miss Juanita La Mar 5301 Michigan
 18. BURIAL, CREMATION, OR REMOVAL PLACE Calumet DATE Mar 6 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. M. Newcomer Sons 2111 Birch Creek + Paseo
 20. FILED Mar 3 1939 M. M. Brown Local Registrar

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.

Med. Adv. No. 5150

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..... *Neil Carr*
Licensed Embalmer No. *3976*

P. O. Address.....

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, above space should be left blank.