

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Little Blue
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 9 yrs. 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 yrs
 (Specify whether
 In this community. Unknown
 years, months or days)

3. (a) PRINT FULL NAME Thomas Greenan

3. (b) If veteran name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased May 10 1865
 (Month) (Day) (Year)

8. AGE: Years 75 Months ✓ Days 201 If less than one day hr. min.

9. Birthplace Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER
 { 12. Name Unknown
 { 13. Birthplace Unknown
 { 14. Maiden name Unknown
 { 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. F. McEathery
 (b) Address Jackson C. Home

17. (a) removal (b) Date thereof June 3-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Kirkville Colof Ct

18. (a) Signature of funeral director R. C. Moore
 (b) Address Betterville

19. (a) 7-2-40 (b) David G. Burns
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town Little Blue
 (If outside city or town limits, write "RURAL")
 (d) Street No. J. C. Home
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
 year 1940 hour 11 minute 20 A.

21. I hereby certify that I attended the deceased from 5-15, 1940 to 6-1, 1940
 that I last saw him alive on 5-30, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral regurgitation Duration

Due to
 Due to 92 W
 Other conditions (Include pregnancy within 3 months of death)

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)
 Did injury occur in or about home, on farm, in industrial place, in public place?
932 (Specify type of place)
 While at work (e) Means of injury

23. Signature J. H. Greene (M. D. or other)
 Address Independence Mo Date signed 6/6-40

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.

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 *W. L. Ward*

Licensed Embalmer No. 3991

P. O. Address 5725 Virginia

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.

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