

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Joseph Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10 days**  
(Specify whether  
In this community **53 yrs.**  
years, months or days)

3. (a) PRINT FULL NAME **Mr. Dennis GREEN. 650**

3. (b) If veteran, **None** name war  
3. (c) Social Security No. **no**

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

6. (b) Name of husband or wife **Mrs. Nell Green.** 6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **January 21st, 1867**  
(Month) (Day) (Year)

8. AGE: Years **13 70** Months **6** Days **14** If less than one day hr. min.

9. Birthplace **Cork Ireland 5**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Asst. Fire Chief.**

11. Industry or business

12. Name **Patrick Green**  
13. Birthplace **Ireland 5**  
(City, town, or county) (State or foreign country)

14. Maiden name **Kittle Soonish**  
15. Birthplace **Ireland 5**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nell Green**  
(b) Address **6440 Morningside Drive.**

17. (a) **Burial** (b) Date thereof **8/8/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Melody-McGilley.**

(b) Address **K. C. Mo.**

19. (a) **Aug. 7, 1940** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **6440 Morningside Drive.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? **53 yrs.** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **5th**  
year **1940** hour **5:00** minute **2** M.

21. I hereby certify that I attended the deceased from **July 21**  
**1940** to **Aug 5** **1940**  
that I last saw him alive on **Aug 5** **1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death. **Empyema of R. P. & Lung abscess.** **14 days**  
**Duration**

Due to **Gall stones**

Other conditions **127**  
(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)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury **1**

23. Signature **W. W. Gier** (M. D. or other)  
Address **957 Argyle Bldg** Date signed **8/7/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Dr. Gist.  
Argyle Bldg.

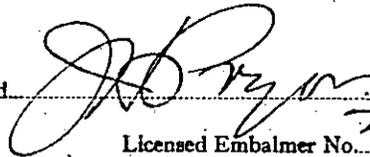
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**STATEMENT BY LICENSED EMBALMER**

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. 267.  
working under my personal supervision.

Signed



Licensed Embalmer No. 2999

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.**