

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days
(Specify whether years, months or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 91st and State Line
(If rural, give location)
(e) If foreign born, how long in U. S. A.? no. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 5th,
year 1940, hour 1:30 minute P. M.
21. I hereby certify that I attended the deceased from August 17th
1940, to Sept 5th, 1940,
that I last saw him alive on Sept. 5th, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death
Massive pulmonary embolism Duration 45 min.

Due to Cerebral thrombosis with Duration 20 days
Due to hemiplegia

Other conditions
(Include pregnancy within 3 months of death) 82 P

Major findings:
Of operations _____
Of autopsy Pulmonary embolism
Cerebral thrombosis. Sclerosis of cerebral vessels.

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?
361
While at work? _____ (Specify type of place) _____
(e) Means of injury fall

23. Signature Ed N Zlein (M. D. or other) _____
Address KC Mo. Date signed 9/5/40

3. (a) PRINT FULL NAME Joe B. Green

8. (b) If veteran, name war No. 3. (c) Social Security No. # in District Off.

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

6. (b) Name of husband or wife Mabel Green 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased November 9, 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 9 26 hr. min.

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

10. Usual occupation District Sales Manager

11. Industry or business X

12. Name William Green

13. Birthplace Texas
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mabel Green

(b) Address 91st and State Line, K. C.

17. (a) Burial (b) Date thereof 9-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (e) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

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

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

Dr. Ed H. Kline,

2121 1/2
Plumtree
Bldg
Med.

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 J. B. Waters
Licensed Embalmer No. 3992
P. O. Address N. C. Mo

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.