

No. 2
-13-40
17-39
X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37571

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4169

FILED DEC 11 1940

1. PLACE OF DEATH: Jackson
 (a) County: Kansas City
 (b) City or town: (If outside city or town limits, write "RURAL" and name of town)
 (c) Name of hospital or institution: St. Mary's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. (Specify whether)

3. (a) PRINT FULL NAME: John Allen Greaves

3. (b) If veteran, name war: XX
 3. (c) Social Security No.: XX

4. Sex: Male
 5. Color or race: Wh
 6. (a) Single, widowed, married, divorced: Sgl

6. (b) Name of husband or wife: XX
 6. (c) Age of husband or wife if alive: XX years

7. Birth date of deceased: Oct. 31 1940
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 0 0 0 6 hr. min.

9. Birthplace: Kansas City Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation: None

11. Industry or business: 1

MOTHER FATHER
 12. Name: John Allen Greaves
 13. Birthplace: Kansas City Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name: Jeanne Larue Conklin
 15. Birthplace: Enid Okla.
 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. E. A. Greaves

(b) Address: 7303 Madison
 (Burial, cremation, or removal) (b) Date thereof: 11-1-1940
 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Moriah Cem.

18. (a) Signature of funeral director: W. Wagner
 (b) Address: Kansas City, Mo.

19. (a) 11-1-40 (b) M. M. Crome
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County: Jackson
 (c) City or town: Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 7303 Madison
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 31 day
 year 1940 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct 31 - 40
 19 to Oct 31 1940
 that I last saw him alive on Oct 31 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Premature - 7 mo gestation.

Due to: 1/59

Due to: _____

Other conditions: _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

Duration
 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: _____

23. Signature: Edwin C. White (M. D. or other) MD
 Address: 1032 P. 206 Date signed: 11/1/40

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

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

A. R. Harnscheidt

Licensed Embalmer No.

4159

P. O. Address

R. E. MD.

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, fact should be so stated above.