

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: Research Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 25 days  
(Specify whether years, months or days) 25 days

3. (a) PRINT FULL NAME

Babe Green

3. (b) If veteran, name war. X

3. (c) Social Security No. X

4. Sex Girl 5. Color or race White

6. (a) Single, widowed, married, divorced. X

6. (b) Name of husband or wife. X

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased. January 25, 1941  
(Month) (Day) (Year)

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

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

10. Usual occupation. Newborn

11. Industry or business.

12. Name Mark Alfred Green

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

14. Maiden name Marcelle Helen Wilson

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

16. (a) Informant Research Hospital

(b) Address Proby Knotts St K 6 Mo

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

(c) Place: burial or cremation Disposed of by

18. (a) Signature of funeral director Research Hospital

(b) Address

19. (a) 3-24-41 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Miami  
(c) City or town Gaslay  
(If outside city or town limits, write "RURAL")  
(d) Street No. 20th  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28<sup>th</sup>  
year 1941 hour 9<sup>00</sup> minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from January 25, 1941, to March 21, 1941;  
that I last saw her alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death. Chronic Hydrocephalus 25 days

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations 157

Of autopsy. Same as above

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 D

23. Signature E. A. Wilkinson (M. D. certificate) 29  
Address 1103 Grand Ave. Date signed 3/22/41

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

18  
3  
8

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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.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**