

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 950

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution: Wheeler Prodenic Hosp
(d) Length of stay: In hospital or institution 14 days
In this community 14 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass 19
(c) City or town Harrisonville
(d) Street No. 105 Elm
(e) If foreign born, how long in U. S. A.? 1 years.

8. (a) **PRENATAL FULL NAME** Emma Belle Green

8. (b) If veteran, name war _____ 3. (c) Social Security No. None

5. Color of red 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Aug. 29, 1878

8. AGE: Years 63 Months 6 Days 47 If less than one day hr. _____ min. _____

9. Birthplace Topeka Kansas

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Newton M. Afee

13. Birthplace Kentucky

14. Maiden name Not known

15. Birthplace _____

16. (a) Informant Charlyne Overton

(b) Address 2924 Jackson

17. (a) Burial (b) Date thereof Mar 9, 1942

(c) Place: burial or cremation Harrisonville Mo

18. (a) Signature of funeral director Atkinson Bros

(b) Address Harrisonville Mo

19. (a) 3/7/42 (b) M. M. Crowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6 year 1942 hour 9 minute 15 AM

21. I hereby certify that I attended the deceased from 3-2-42 to 3-6-42

that I last saw her alive on 3-5-42 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure

Due to Chr. myocarditis

Due to 56B

Other conditions Fibroma uterus, post-operative

Major findings: Of operations Fibroid uterus

Of autopsy not yet determined

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? _____

(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 W. Wallace Greene (M. D. or other) MD
Address 1103 Grand, Kansas City Date signed 3-7-42

Duration
?
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Floyd Harrison

Licensed Embalmer No.

5920

P. O. Address

Harrisonville

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.