

FILED-APR 1 1949
Registration District No. 3429

Primary Registration District No. 1002

4 2000 80000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: 536 1/2 Walnut
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community unknown years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits write "RURAL")
(d) Street No. 536 1/2 Walnut
(If rural, give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JACKSON L. GREEN

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced unknown
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 72 yrs hr. min.

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

10. Usual occupation unknown

11. Industry or business _____

MOTHER FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Cosmors office
(b) Address Court Adline

17. (a) Serial (b) Date thereof 3/20/42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hill K.C.K.

18. (a) Signature of funeral director John B. Lagetun
(b) Address K.C. Mo

19. (a) 3-20-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day 3-10-42 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that was born alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death Chronic myocarditis

Due to _____
Due to 930
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

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 M. M. Crowe (M. D. or other) _____
Address K.C. Mo Date signed _____

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

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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..... *Harry E. Jolley*
Licensed Embalmer No. *4078*
P. O. Address *Kan City Kan*

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.