V. S. No. 2
DM—9-4-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1942

Registration District No. 349

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 13311

Registrar's No. 1675

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: 315 1/2 East 15th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 315 1/2 East 15th St 8
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) D
If yes, name country

3. (a) PRINT FULL NAME: Green R. Farmer
3. (b) If veteran, name war: NO
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: Martha
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: 5 (Month) 14 (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
75	11	14	..... hr. ..... min.

9. Birthplace: Kentucky (City, town, or county) (State or foreign country)
10. Usual occupation: Teamster
11. Industry or business:
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: E. F. Nevoste
(b) Address: 3308 Olive
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 4/29/42 (Month) (Day) (Year)
(c) Place: burial or cremation: Shelburne Mo
18. (a) Signature of funeral director: Brown Mayberry
(b) Address: 2315 Linwood
19. (a) 4-29-42 (Date received local registrar) (b) M. M. Crowen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 28-42 year ..... hour ..... minute 3:10 P.M.
21. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 ..... ; that I last saw him alive on ..... 19 ..... ; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion
Due to: Coronary Atherosclerosis
Due to:
Other conditions (Include pregnancy within 3 months of death): Hypertrophy Prostate
Major findings: Of operations: 940
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? (Specify type of place)
While at work (e) Means of injury
23. Signature: Russell Wyeth (M.D. or other)
Address: K. C. Mo Date signed

361 (Licensed Embalmer's Statement on Reverse Side)

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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K. 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, fact should be so stated above.