

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

2636

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

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:  
General Hospital No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5-4-42-6-30-42  
(Specify whether years, months or days)

In this community 22 years

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. 1626 Campbell  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARIE GREEN

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30  
year 1942 hour 8 minute 00 a. m.

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased April 3 1910  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 4 1942 to June 30 1942; that I last saw her alive on June 30 1942 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>32</u>	<u>2</u>	<u>27</u>	hr. _____ min. _____

Immediate cause of death Primary Adeno-Carcinoma of cervix with generalized carcinomatosis

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

10. Usual occupation Unemployed

Due to \_\_\_\_\_

Due to 4 1/2 hr

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Same as above

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) burial (b) Date thereof 7/10/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Hickins Bros.

(b) Address 1729 Lydia

19. (a) 7-10-42 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

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)

Means of injury i

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Gen. Hosp #2-60 E 22 Date signed 7-1-42

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.....

*J. Manlove*  
.....  
Licensed Embalmer No. *3994*

P. O. Address.....

*2503 Highland*

**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.**