

41003

S. No. 2
OM-2-43
5-17-39
X 35967

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **5319**

FILED JAN 3 1944
Registration District No. 149

Primary Registration District No. 1002

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 18 days
(Specify whether years, months or days)

In this community 42 years
(Specify whether years, months or days)

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. 4407 Penn
(If rural, give location)

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

3. (a) PRINT FULL NAME Addison Green

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 Married

6. (b) Name of husband or wife Laura Bella Green 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased October 12th 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 2 Days 3 If less than one day
hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Dry Goods Merchant

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Laura Belle Green

(b) Address 4407 Penn Street

17. (a) Burial (b) Date thereof 12/18/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Fresman Mortuary

(b) Address 104 West 42nd street

19. (a) 12-16-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15
year 1943 hour 1 minute 10 A.M.

21. I hereby certify that I attended the deceased from October 3 1943 to December 15 1943.
that I last saw him alive on December 15 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration _____

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

Major findings:
Of operations _____
Of autopsy _____

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? _____

While at work _____ (Specify type of place) Means of injury _____

23. Signature Amey R. Thorn (M. D. or other) 12-15-43
Address Med. Dir. Gen'l Hosp. Date signed _____

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 Elmer C. Medelie

Licensed Embalmer No. 3495

P. O. Address N. C. 240

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.