

FILED OCT 9 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3861

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:
622 Cypress
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 31 Years
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. 622 Cypress
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Hattie Lytle Green

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife James Green 6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased 4 16 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 5 6 hr. min.

9. Birthplace Saline Co., Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

MOTHER FATHER
11. Industry or business
12. Name J.W. Lytle
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Pauline Schuyler
15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Margaret C. Green
(b) Address 622 Cypress

17. (a) Burial (b) Date thereof 9-25-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Mt Washington
18. (a) Signature of funeral director Mrs. C.L. Forster
(b) Address Kansas City, Mo.

19. (a) 9-25-44 (b) N. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 22nd.
year 1944 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from 6-1-32
19..... to 9-22 19 44
that I last saw her alive on 9-21 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration

Due to Arterio-sclerosis

Due to 4301

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) (e) Means of injury

23. Signature D. P. Redding D.O. (M. D. or other)
Address 5111 Independence Ave. Date signed 9-23-44

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

Dr. D.P. Redding
Be 6808

5111 Snodgrass Ave
2.16.6 Return

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. H. Hennick
Licensed Embalmer No. 25-89
P. O. Address MEMO

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.