

V. S. No. 2  
100M-5-43  
Rev. 5-17-39  
I X34671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 13 1944

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33165  
State File No.  
4253  
Registrar's No.

Registration District No. 179 Primary Registration District No. 1002

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:  
4443 Jefferson  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 45 years  
years, months or days

3. (a) PRINT FULL NAME Mrs. Laura B. Green  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife Addison Green  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 21st 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 6 2 hr. min.

9. Birthplace West Virginia  
(City, town, or county) (State or foreign country)  
10. Usual occupation At home  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name James C. Cline  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Lamar Raymond  
15. Birthplace West Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charles E. Kocher  
(b) Address 4443 Jefferson

17. (a) Burial (b) Date thereof 10-25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Washington Cemtery

18. (a) Signature of funeral director Freeman Mortuary  
(b) Address Kansas City, Mo.

19. (a) Oct 24 1944 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

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. 4443 Jefferson  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 23rd  
year 1944 hour 11:15 P.M. minute 15 P.M.  
21. I hereby certify that I attended the deceased from Oct 23 1944 to Oct 23 1944  
that I last saw her alive on Oct 23rd 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 3 1/2 hrs  
Arterio-sclerosis years  
Due to \_\_\_\_\_  
Due to 94a  
Other conditions (Includes 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)  
(a) Means of injury \_\_\_\_\_  
23. Signature W. Anderson (M. D. or other) \_\_\_\_\_  
Address 723 W 45th St Date signed 10-24-44

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 W. H. Erwin

Licensed Embalmer No. 4352

P. O. Address Id. 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.**