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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 17 1945
149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Jackson County

(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
(If not in hospital or institution, write street number or location)

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

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 58

(c) City or town Brookfield
(If outside city or town limits, write "RURAL") 2

(d) Street No. 712 E 8th
(If rural, give location)

(e) Citizen of foreign country? X (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Gus Green

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. mar.

6. (b) Name of husband or wife Pearl Green 6. (c) Age of husband or wife if alive. 51 years

7. Birth date of deceased Aug. 22, 1889
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>4</u>	<u>12</u>	hr. _____ min. _____

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

12. Name G. M. Green

13. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Webb

15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Work Record
(b) Address K. C. Mo.

17. (a) removal (b) Date thereof 1-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield, Mo.

18. (a) Signature of funeral director Stine & McClure,
3235 Gillham Plaza, K. C., Mo.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 4
year 1945 hour 11:59 minute _____ 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 Sq. Ca. of rt. tonsillar fossa Asperative pneumonia

Due to _____

Due to _____

Other conditions 5-5-45
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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? _____

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

23. Signature A. E. Wacker (M. D. or other) MO.

Address Genl Wacker Date signed _____

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

copy

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.....

W. J. Allen..... Registered Apprentice No. *1415*
working under my personal supervision.

Signed..... *W. J. Allen*

Licensed Embalmer No. *1415*

P. O. Address.....

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.