

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 5 1945/9

Registration District No. _____ Primary Registration District No. 1002

Registrar's No. 1358

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:
4216 Roanoke Road
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 30 years

3. (a) PRINT FULL NAME Athol C. Green
 3. (b) If veteran, name war no
 3. (c) Social Security No. 487-12-2960

4. Sex Male 5. Color or race white
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mrs Clara Green
 6. (c) Age of husband or wife if alive 60 years
 7. Birth date of deceased June 10th 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 9 8 12 hr. min.

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

10. Usual occupation Retired Railroad Clerk

MOTHER FATHER

11. Industry or business _____
 12. Name Eugene Green
 13. Birthplace Indiana
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Clara Green
 (b) Address 4216 Roanoke Road

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-45
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address 1800 Linwood Kansas City Mo

19. (a) 3-24-45 (Date received local registrar) (b) J. Holmes (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. 4216 Roanoke Road
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22nd year 1945 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from Jan 10/45 to Mar 27 1945
 that I last saw him alive on Mar 20 1945
 and that death occurred on the date and hour stated above

Immediate cause of death Coronary Thrombosis
 Due to Carcinoma left Jaw
 Duration 2 yrs

Due to _____
 Other conditions 45 d
(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 J. Holmes (M. D. or other) MD
 Address 901 Westport Rd Date signed 3/23/45

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

Dr. Lee Haynes
901 Westport
Va. 9593

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 Edwin E. Heck

Licensed Embalmer No. 4063

P. O. Address 1800 Linwood Blvd

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.