V. S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29677

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4051

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: Osteopathic Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9-13-45 - 9-29-45 (Specify whether
In this community 26 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. 1322 E. 30th St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME MRS MINNIE A. GREEN
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or race W.
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Guy
6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased 8 (Month) 3 (Day) 1874 (Year)
8. AGE: Years 71 Months 1 Days 26 If less than one day hr. min.
9. Birthplace (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Housewife
11. Industry or business At home
FATHER 12. Name Olf Erickson
13. Birthplace (City, town, or county) Sweden (State or foreign country)
MOTHER 14. Maiden name Elizabeth Mattson
15. Birthplace (City, town, or county) Sweden (State or foreign country)
16. (a) Informant Guy W. Green
(b) Address 1322 E. 30 St. K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation Stromberg Neb
18. (a) Signature of funeral director STINE-McCLURE
(b) Address KANSAS CITY, MO
19. (a) 10-2-45 (Date received local registrar) (b) Ethaedine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 29th year 1945 hour 2 minute 30 P.M.
21. I hereby certify that I attended the deceased from 9-13-45 to 9-28 1945; that I last saw her alive on 9-28 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial failure	2 da
Due to Transverse Myelitis	?
Due to none	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations none 82'1
Of autopsy none

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? (Specify type of place)
While at work (e) Means of injury
23. Signature N. S. Miller (M. D. or other) D.O.
Address 2603 East 31st Date signed 10-1-45

(Licensed Embalmer's Statement on Reverse Side)

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

Dr Polden
2603 E 31

AUG 10 1954

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address K. 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.