V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33912

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 72

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

48
0
0

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Rural (If outside city or town limits, write "RURAL" and name of township) Washington
(c) Name of hospital or institution: 8305 Flora Avenue (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 2 mos years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City Rural (If outside city or town limits, write "RURAL")
(d) Street No. 8305 Flora 0 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM SHERMAN GREENE

3. (b) If veteran, name war NO
3. (c) Social Security No. NONE

4. Sex MALE 0
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED 1
6. (b) Name of ~~husband or~~ wife MRS LOTTIE GREENE
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased NOVEMBER (Month) 6 (Day) 1881 (Year)

8. AGE: Years 63 Months 11 Days 1 If less than one day ..... hr. ..... min.

9. Birthplace CAMERON (City, town, or county) MISSOURI 0 (State or foreign country)
10. Usual occupation FARMER
11. Industry or business
FATHER
12. Name KUYLER GREENE
13. Birthplace FORT ANN (City, town, or county) N.Y. 1 (State or foreign country)
MOTHER
14. Maiden name ROSE PETERSON
15. Birthplace ..... (City, town, or county) PA. 1 (State or foreign country)
16. (a) Informant Mrs Lottie Greene
(b) Address 8305 Flora Avenue
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1945 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Berryville, Okla.
18. (a) Signature of funeral director D. H. Newcomer Sons
(b) Address 1401 Brush Creek
19. (a) 10/10/45 (Date received local registrar) (b) Dr. Annie G. Hedges (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 7 year 1945 hour 8 minute 45th M.
21. I hereby certify that I attended the deceased from Sept 27 45 ....., 19..., to ....., 19...; that I last saw him alive on ~~Sept~~ Oct 2, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Congestive heart failure	3 wks
Due to Chronic myocarditis & endocarditis	?
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 93d

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 Clyde Switzer (M. D. or ~~other~~)
Address 636 Argyle Bldg Kansas City Mo Date signed 10-7-45

1152

(Licensed Embalmer's Statement on Reverse Side)

Ida Sunteyer
112 Huntington Road

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 E. Oscar Worthy

Licensed Embalmer No. 1767

P. O. Address Kansas City 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.