

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40604  
5349  
Registrar's No.

**FILED DEC 31 1946**  
Registration District No. 199

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson  
(a) County Kansas City  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
(Specify whether 0)  
In this community 30 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED: Jackson  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4211 Indep. Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 1)

3. (a) PRINT FULL NAME Clyde Milton Green  
3. (b) If veteran, name war None 3. (c) Social Security No. 499-14-2140  
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 29 1903  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
42 11 20 hr. min.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec: day 19th  
year 1946 hour 2 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 12-10-46, 1946 to 12-19-46, 1946  
that I last saw him in alive on 12-19-46, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: 13/4  
(Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy: See above  
Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

9. Birthplace California  
(City, town, or county) (State or foreign country)  
10. Usual occupation Waiter  
11. Industry or business \_\_\_\_\_  
12. Name Thomas M. Green  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Rosa Huffman  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Rosa Agee  
(b) Address 4211 Indep. Ave. K.C. Mo.  
17. (a) Burial (b) Date thereof 12-21-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Calvary: K.C. Kan.  
18. (a) Signature of funeral director Weilert Funeral Home  
(b) Address Kansas City, Mo.  
19. (a) 12-21-46 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature Wm W. Hart (M. D. or other) Med  
Address Med. Dir. K.C. Gen. Hospital Date signed 12-20-46

MOTHER FATHER

**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 Blaine E. Weiler

Licensed Embalmer No. 4075

P. O. Address. K.C. Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**