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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1948

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4006

Primary Registration District No. 1000

Registrar's No. 226

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 yr 10 Mo 8 days (Specify whether years, months or days)

In this community 8 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Holt 4d

(c) City or town: Oregon
(If outside city or town limits, write "RURAL")

(d) Street No.: Oregon
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: KATE GREENE

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Female

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: Sept (Month) 20 (Day) 1875 (Year)

8. AGE: Years 72 Months 4 Days 28 If less than one day hr. min.

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

10. Usual occupation: Clerical

11. Industry or business:

FATHER
12. Name: James Green
13. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Susan Young
15. Birthplace: Unknown (City, town, or county) Penn (State or foreign country)

16. (a) Informant: Record Hospital
(b) Address: St Joseph Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/18/1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Sturgeon Bay, Wisconsin.

18. (a) Signature of funeral director: Walter Meierhoffer
(b) Address: St. Joseph, Missouri.

19. (a) 2-24-48 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18 year 1948 hour 5-15 minute P M.

21. I hereby certify that I attended the deceased from February 2, 1948, to Feb. 18, 1948 that I last saw her alive on 2-18, 1948 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Myocardial degeneration

Due to: arteriosclerosis

Due to:

Other conditions (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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: E. E. Flossins (M. D. ~~or other~~)

Address: St Joseph Mo Date signed 2-18-48

(Licensed Embalmer's Statement on Reverse Side) State Hospital #2

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. Elbert E. Harrington

Licensed Embalmer No. 3258 Mo.

P. O. Address St. Joseph, 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.