

FILED MAR 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9129**
Registrar's No. **94**

BIRTH NO. _____ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Independence c. LENGTH OF STAY (in this place) 42-45		c. CITY OR TOWN Independence d. STREET ADDRESS (If rural, give location) 319 N. Spring	
d. FULL NAME OF HOSPITAL OR INSTITUTION 319 N. Spring			

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Wayne c. (Last) Greene	4. DATE OF DEATH (Month) (Day) (Year) Mar 6 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec 10-1877	9. AGE (In years last birthday) 72	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY Med	11. BIRTHPLACE (State or foreign country) Raytown, Mo	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Shades W Greene	13b. MOTHER'S MAIDEN NAME Elyza Ann Campbell	14. NAME OF HUSBAND OR WIFE Ann Josephine Minnedy
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes 1st World War	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ann Josephine Greene	ADDRESS Greene
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Occlusion		INTERVAL BETWEEN ONSET AND DEATH- Minutes
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chron. Myo. Carditis		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 47.01			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **2/10 1949**, to **3/6 1950**, that I last saw the deceased alive on **2/5 1950**, and that death occurred at **7:00 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE J. S. Donaldson M.D. (Degree or title)	23b. ADDRESS 408 Argyle Bldg.	23c. DATE SIGNED 3/7/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 5, 1950	24c. NAME OF CEMETERY OR CREMATORY Woodlawn	24d. LOCATION (City, town, or county) (State) Independence
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DATE REC'D BY LOCAL REG. Mar. 7-1950	REGISTRAR'S SIGNATURE J. S. Donaldson	25. FUNERAL DIRECTOR'S SIGNATURE Att. Mitchell ADDRESS Indep Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0464

MAR 13 RECD

JAN 15 1951

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Henry J. Mitchell

Licensed Embalmer No. 3925

P. O. Address Andes, 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.