

FILED NOV 3 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33588

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4439

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>	c. LENGTH OF STAY (In this place) <u>life</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> <u>148</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>400 Westover Road</u> <u>300</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Francis</u>	b. (Middle) <u>W.</u>	c. (Last) <u>Green</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>October 17, 1951</u>
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5. SEX <u>male</u> <u>0</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u> <u>0</u>	8. DATE OF BIRTH <u>9-22-1883</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Wholesale Grocer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Kansas City, Missouri</u> <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Thomas Green</u>	13b. MOTHER'S MAIDEN NAME <u>Bridgett Smith</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Christine D. Green 400 Westover Rd.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>45<sup>00</sup></u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac failure - auricular fibrillation</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>malnutrition + arteriosclerosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)	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 June, 1949, to Oct 17, 1951, that I last saw the deceased alive on Oct 16, 1951, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Geraldine Holmes</u> <u>Doyle C. Whitman, D. M.D.</u> (Degree or title)	23b. ADDRESS <u>1003 Shaw Bldg. K.C. Mo</u>	23c. DATE SIGNED <u>10-18-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> <u>0</u>	24b. DATE <u>10-19-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Mary's</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10-18-51</u>	REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. W. Wagner Kansas City, Missouri</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 \_\_\_\_\_  
working under my personal supervision. \_\_\_\_\_ Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed.....  
Licensed Embalmer No.....

P. O. Address.....

**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.