

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42924**

1-14-54
FILED JAN 14 1954

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|---|--|--|--|--|--|---|---|--|---------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. _____ | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> | | | | b. COUNTY <u>Jackson</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | | c. LENGTH OF STAY (in this place) <u>2 yrs</u> | | c. CITY OR TOWN <u>Kansas City</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2432 Troost</u> | | | | e. STREET ADDRESS (If rural, give location) <u>42 2432 Troost 3438</u> | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah C.</u> | | | b. (Middle) _____ | | | c. (Last) <u>Green</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>12-24-53</u> | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u> | | 8. DATE OF BIRTH <u>Sept-23-1915</u> | | 9. AGE (In years last birthday) <u>38</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 10 HRS: Hours _____ Mins _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or an if retired) <u>House work</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Washington Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Mo</u> | | | |
| 13a. FATHER'S NAME <u>Arthur Green</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Annette Surber</u> | | | 14. NAME OF HUSBAND OR WIFE <u>None</u> | | | | |
| 15. WAS DEPOSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ellen Semler Wellington</u> | | | | ADDRESS <u>Mo</u> | | |
| 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) <u>Lobar Pneumonia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>490X</u> | | |
| | | | | ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ | | | | | | |
| | | | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral Sines & meningeal sinus</u> | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION <u>Gastrointestinal Dist</u> | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Natural</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) _____ | | (COUNTY) _____ | | (STATE) _____ | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) m. _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | | | | |
| 23a. SIGNATURE <u>Hugh A. Owens</u> (Degree or title) | | | | 23b. ADDRESS <u>Corner 1034 E. 12th St. Platt</u> | | | 23c. DATE SIGNED <u>12-26-53</u> | | | |
| 24a. BURIAL - CREMATION - REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>12-26-53</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>City Center</u> | | 24d. LOCATION (City, town, or county) (State) <u>Wellington Mo</u> | | | | |
| DATE REC'D BY LOCAL REG. <u>12-26-53</u> | | REGISTRAR'S SIGNATURE <u>Heraldine Smith</u> | | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Lane</u> | | | | ADDRESS <u>Wellington Mo</u> | |

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 4273
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.