

FILED FEB 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4815

461

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|-----------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. _____ | | | |
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). | | | | | |
| a. COUNTY <u>JACKSON</u> | | | | 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>3 YRS</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>KRESTWOOD MED. HOSPITAL</u> | | | | STREET ADDRESS (If rural, give location) <u>6821 MONTGALL AVENUE</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | | | | | |
| a. (First) <u>GERTRUDE</u> | | | b. (Middle) _____ | | | c. (Last) <u>GREEN</u> | | | |
| | | | 4. DATE OF DEATH | | | <u>JAN 30 1955</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u> | | 8. DATE OF BIRTH <u>APRIL-3-1873</u> | | | |
| 9. AGE (In years last birthday) <u>81</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 1 HRS. Hours _____ Min. _____ | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | | 11. BIRTHPLACE (City and State or Foreign Country) <u>DES ARC, Mo</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13a. FATHER'S NAME <u>FLYNN SULLIVAN</u> | | 13b. MOTHER'S MAIDEN NAME <u>LUCINDA CROWE</u> | | 14. NAME OF HUSBAND OR WIFE <u>JOHN GREEN</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | 17. INFORMANT'S SIGNATURE OR NAME <u>MRS. ROY McNALLY</u> | | ADDRESS <u>6821 MONTGALL KCMO</u> | |
| 18. CAUSE OF DEATH | | | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Enter only one cause per line for (a), (b), and (c) | | | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Thrombosis of Cerebral Artery</u> | | | | <u>3 days</u> | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | ANTECEDENT CAUSES | | | | | |
| | | | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | |
| | | | | DUE TO (b) <u>Arteriosclerosis</u> | | | | <u>5 years +</u> | |
| | | | | DUE TO (c) _____ | | | | | |
| | | | | II. OTHER SIGNIFICANT CONDITIONS | | | | | |
| | | | | Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Heart Disease</u> | | | | <u>3 yrs plus</u> | |
| | | | | <u>Broncho pneumonia (Terminal)</u> | | | | <u>36 hours</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | <u>332X</u> | | | | | |
| 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) | | | | | |
| | | | | | | | | | |
| 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? | | | | | |
| | | | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 2, 1951</u> , to <u>Jan 30, 1955</u> , that I last saw the deceased alive on <u>Jan 30, 1955</u> , and that death occurred at <u>11:45A.M.</u> , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE <u>R. R. Becker</u> (Degree or title) <u>MD</u> | | | | 23b. ADDRESS <u>4000 Baltimore Kansas City, Mo</u> | | | | 23c. DATE SIGNED <u>1/30/55</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 24b. DATE <u>FEB 1, 1955</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>WOOD CEMETERY</u> | | 24d. LOCATION (City, town, or county) (State) <u>PIEDMONT, MO</u> | | | |
| DATE REC'D BY LOCAL REG. <u>2-1-55</u> | | REGISTRAR'S SIGNATURE <u>Neva Minshall</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Newcomer</u> | | ADDRESS <u>1337 BRUSH CREEK K.C. Mo.</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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..... *Edward M. Stone*

Licensed Embalmer No. *493*

P. O. Address *K.C., 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.