

Health, Welfare and Public Service  
 300 -56  
 Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FILED JUN 17 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 20121

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 543

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Crawford</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Walnut</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1128 W. University</b>		Length of stay in lb <b>4 weeks</b>	d. STREET ADDRESS (If outside, give location) <b>No street address</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>A.</b> Last <b>GREEN</b>			4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1893</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Lbr. Co.</b>	11. BIRTHPLACE (City and state or country) <b>Thomas Co. Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Green</b>			14. MOTHER'S MAIDEN NAME <b>Anna Kutscher</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>512-03-0608</b>	17. INFORMANT Address <b>Harlan Green, Springfield, Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myelogenous Leukemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>4-27-56</b> to <b>6-11-57</b> and last saw <del>her</del> <b>him</b> alive on <b>6-11-57</b> Death occurred at <b>4:30 p.m.</b> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Harold H. Lurie, M.D.</b> (Degree or title)			22b. ADDRESS <b>609 Cherry Springfield, Mo.</b>		22c. DATE SIGNED <b>6-12-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>June 11, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		23d. LOCATION (City, town, or county) (State) <b>Walnut, Kansas</b>	
24. FUNERAL DIRECTOR <b>Jewell E. Windle</b>		ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-12-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JUL 9 1957  
JUN 24 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert E. Muham*.....

Licensed Embalmer No. *49*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.