

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025147

Health,
Welfare
Public
Service

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-57

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1.002 STATE FILE NUMBER 3225 Registrar's No. 3225

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 (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1724 Manchester		Length of stay in 1b 30 Yrs	d. STREET ADDRESS (If outside, give location) 1724 Manchester Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARTHA Middle JANE Last GREEN			4. DATE OF DEATH Month June Day 30 Year 1959			
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1 1873	9. AGE (In years last birthday) 86	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) Minister	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Excelsior Springs Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Ben Williams	13b. MOTHER'S MAIDEN NAME Mary Ann Wellington	14. NAME OF HUSBAND OR WIFE John F Green
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT John F Green 1724 Manchester K C Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis Generalized</u>		<u>25 years</u>
	DUE TO (c) <u>Senility</u>		<u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	

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, Year _____ 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 K	COUNTY	STATE Y
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21. I attended the deceased from January 18, 1959 to June 30, 1959 and last saw her alive on June 23, 1959
Death occurred at 9:30 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William D. Hand, Jr., D.D.</u>	22b. ADDRESS <u>605 Woodland</u>	22c. DATE SIGNED <u>7-1-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-3-59	NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-1-59	26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>
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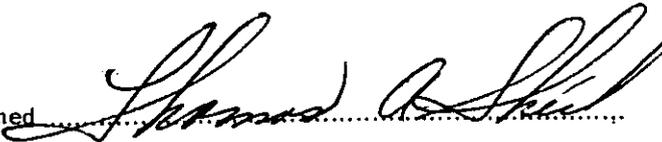
All diseases in Part I must be causally related.
William D. Hand, Jr. Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. 
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.