

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025150

FILED VS JUL 27 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3416 STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>31 YRS.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7015 Indiana Ave.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7015 Indiana Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M</u> Last <u>Greenlee</u>			4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>84</u> IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.
11. BIRTHPLACE (City and state or county) <u>OSKALOOSA, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Antoine Morgan</u>		13b. MOTHER'S MAIDEN NAME <u>HELEN LUCINDA COX.</u>	
14. NAME OF HUSBAND OR WIFE <u>C.W. Greenlee</u>		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 Address <u>MRS. J. F. DOAK 112 W. 96th TERR</u>	
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>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized and coronary arteriosclerosis unknown</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 <u>May 29, 1959</u> to <u>July 10, 1959</u> and last saw her alive on <u>July 10, 1959</u> . Death occurred at <u>11:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>William F. Sanders M.D.</u>		22b. ADDRESS <u>411 Nichols Road KC Mo</u>	22a. DATE SIGNED <u>July 10, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JULY 13, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomers Sons Kansas City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

DOCUMENT

BY AFFIDAVIT OF WILLIAM F. SANDERS 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Johnson W. Peterson

Licensed Embalmer No. 4889

P. O. Address A. C. 7/0.

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