

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042414

FILED VS DEC 7 1960

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 48

STATE FILE NUMBER

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) OR TOWN HICKMAN MILLS		c. CITY OR TOWN HICKMAN MILLS	
Length of stay in lb 6 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If not in hospital, give location) IN REAR OF TRAILOR ON GROUND		d. STREET ADDRESS (If outside, give location) 10802 SOUTH 71 HIGHWAY	
HOSPITAL OR INSTITUTION 10802 SOUTH 71 HIGHWAY		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ROBERT Middle LEE Last GREEN			4. DATE OF DEATH Month DECEMBER Day 2 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/25/1912	9. AGE (last birthday) 48	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY KANSAS CITY, MISSOURI ELMWOOD CEMETERY	11. BIRTHPLACE (City and state or country) JASPER COUNTY, MO.	12. CITIZEN OF WHAT COUNTRY U. S. A.
---	--	---	--

13a. FATHER'S NAME DAVID ALBERT GREEN	13b. MOTHER'S MAIDEN NAME MARY HESTER WOOLARD	14. NAME OF HUSBAND OR WIFE MRS. RUBY COOPER
---	---	--

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 10319 OAKLAND MRS. RUBY COOPER HICKMAN MILLS, MO.
---	----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH
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)		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 checked="" 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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 8:43 A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Angel A Owens Coroner	22b. ADDRESS 152 Union Station	22c. DATE SIGNED 12-26
--	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 3, 1960	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
--	----------------------------------	---	--

24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 12-3-60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

E K George

JAN 10 1961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *Raymond M. Haro*

Licensed Embalmer No. *4913*

P. O. Address *Indep. M*

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.