

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-015236

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1903

FILED APR 20 1962

VS 300
Rev. 4/59

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2540

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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>LAFAYETTE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in lb <u>6 WEEKS</u>	c. CITY OR TOWN <u>ODESSA</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RESEARCH HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 MILES EAST</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First Middle Last <u>WILLIAM COE GREEN</u>			Month Day Year <u>APRIL 4 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	9. AGE (last birthday) <u>76</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>ODESSA, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>J. HENRY GREEN</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH WAGONER</u>	14. NAME OF HUSBAND OR WIFE <u>MARY BERNETT GREEN</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No NONE</u>		17. INFORMANT Address <u>MELVIN GREEN, MAYVIEW, MISSOURI</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uremia</u>			<u>Feb. 21 '62</u>
DUE TO (b) <u>Nephro-sclerosis</u>			<u>Apr 4 '62</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <u>Post-Oper Rt. Proas Muscle Abscess</u>			
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. Month, Day, Year 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 <u>February 21, 1962</u> to <u>April 4, 1962</u> and last saw him alive on <u>April 3, 1962</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Lee Hoffman MD</u> (Degree or title)		22b. ADDRESS <u>1019 Perry Side K.P. Mo</u>	22c. DATE SIGNED <u>Apr 5-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4-5-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mc KENDREE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ODESSA Missouri</u>
24. FUNERAL DIRECTOR <u>JONES MORTUARY</u>		ADDRESS <u>ODESSA, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>4-5-62</u>
		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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

John R. Sidmon

Licensed Embalmer No. 4531

P. O. Address Kansas City, 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.