

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031013

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4507

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 14 1962

1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 50 years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1217 Oakley Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1217 Oakley Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Rice Last Green		4. DATE OF DEATH Month September Day 1 Year 1962	
5. SEX Male	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 5/21/1884
9. AGE (last birthday) 78		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	10b. KIND OF BUSINESS OR INDUSTRY self
11. BIRTHPLACE (City and state or country) Clark, Missouri		12. CITIZEN OF WHAT COUNTRY U S	
13a. FATHER'S NAME Calvin Green		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Mrs. Rexie Green		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
17. INFORMANT Mrs. Rexie Green		Address 1217 Oakley	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Essential Hypertension DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH. unknown unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) arthritis			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>June 1st 1958</u> to <u>9-1-62</u> and last saw him alive on <u>9-1-62</u> Death occurred at <u>11 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M. F. Sewell M.D.</u>		22b. ADDRESS <u>1722 W 39th St. Mo</u>	
22c. DATE SIGNED <u>9-1-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE <u>9/4/1962</u>		23c. NAME OF CEMETERY OR CREMATORY Memorial Gardens	
23d. LOCATION (City, town, or county) (State) Johnson County, Kansas		24. FUNERAL DIRECTOR ADDRESS Earp & Sons Kansas City, Mo.	
25. DATE RECD. BY LOCAL REG. <u>9-1-62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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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 William H. Eary

Licensed Embalmer No. 4728

P. O. Address A. C. 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.