

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

12943

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. 2405 Forest Ave.) St. _____ Ward _____

File No. _____
Registered No. 1872
St. _____ Ward _____

2. FULL NAME Max Green

(a) Residence No. 2405 Forest Ave. St. 4 Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 1st yrs. mos. ds. How long in U.S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Etta Green

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

| | | | | |
|--------|-----------|----------|----------|--|
| 7. AGE | —YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
| | <u>69</u> | <u>-</u> | <u>-</u> | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Russia

10. NAME OF FATHER Eddel Green

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Russia

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Not known

14. INFORMANT Mrs Bertha Jacobs
(Address) 3324 Cleveland Ave.

15. FILED 4/30 1930 M. M. Carrow REGISTRAR
W. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1930 to April 29 1930
that I last saw him alive on April 28 1930 and that death occurred, on the date stated above, at 2:07 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular Heart Disease
92A (duration) 17 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Valvular Insufficiency
(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Symptoms
(Signed) R. A. Wimmer, M. D.

30, 1930 (Address) 23270 most Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sheffield Cemetary DATE OF BURIAL 4-30-30 19

20. UNDERTAKER P. Louis Funeral Director ADDRESS City: 5700

WHITE PLAIN, WITH UNFRINGING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

