

SEP 6 1939

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

28347  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Keau Primary Registration District No. 1002 Registered No. 3349  
 (c) City J. C. Mo. (d) Street No. General Hospital #2 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred vs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Melissa Green  
 (a) Residence, No. 583 Campbell St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-7-1870  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 5 10  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 FATHER 13. NAME Unknown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 17. INFORMANT (ADDRESS) Record Clerk General Hospital #2  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE Aug. 26, 1939  
 19. FUNERAL DIRECTOR (ADDRESS) H. B. Modie, 1820 E. 18th St. J. C. Mo.  
 20. FILED 9/25/39 M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-17, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 8-14, 1939 to 8-17, 1939  
 I last saw her alive on 8-17, 1939 Death is said to have occurred on the date stated above, at 7:40 p. m.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of Stomach & Metastasis 46  
 Date of onset  
 Other contributory causes of importance:  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) B. J. Jones, M. D.  
 (Address) General Hospital #2

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.

STATEMENT BY LICENSED EMBALMER

I, A. B. Moore, Licensed Embalmer No. 2410

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

L. E.

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed A. B. Moore  
Licensed Embalmer No. 2410

**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.)**