

No. 2
1-10-39
11-2-39

AUG 14 1940
Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether
In this community 16 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 7017 Indiana Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mr. G. Franklin Greenhaw

8. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 27 1921
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
19 3 11 hr. _____ min.

9. Birthplace Dade County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business Southeast High School

MOTHER FATHER
{ 12. Name Edward Greenhaw
13. Birthplace Cedar County Missouri
(City, town, or county) (State or foreign country)
{ 14. Maiden name Pearl Montgomery
15. Birthplace Dade County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Edw G Greenhaw
(b) Address 7017 Indiana Ave

17. (a) Burial (b) Date thereof July 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cem.

18. (a) Signature of funeral director D. H. McComber
(b) Address 1401 Brush Creek Blvd

19. (a) July 8, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8,
year 1940 hour 7 minute 10 A.M.

21. I hereby certify that I attended the deceased from July 6,
1940, July 8, 1940,
that I last saw him alive on July 8, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death: Thrombosis

Due to Brain disease

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. M. Crowe (M. D. or other)
Address 1401 Brush Creek Blvd Date signed 7-8-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

792

Dr. O. M. Langh
Commercial
Over Kaminis H
N. K. C.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *A. H. Newcomer Jr.*

Licensed Embalmer No. 4043

P. O. Address N. 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 this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State-Rite No.

Registration District No.

Primary Registration District No.

Registrar's No. 2720

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or (days)

3. (a) PRINT FULL NAME Franklin Greenhaw

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (City, town, or county) (State or foreign country)

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7/8/46 (b) M. M. Grove (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8 - 46
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19....., and that death occurred on the date and hour stated above. Immediate cause of death.....

Brain abscess
Due to isolate counting again in spinal fluid
consulted for
Other conditions..... (include pregnancy within 3 months of death)
Major findings: with meningitis
Of operation.....
Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature M. M. Grove (M. D. or other).....
Address in Kansas City Date signed.....

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 24120

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2730

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) P. F. U. No. 9

3. (c) Social Security No. _____

(b) If veteran, name war _____

19. DATE OF DEATH

Month July day 8
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 7/8/40

19. (a) _____ (b) M. M. Crowley (Registrar's signature)

20. DATE OF DEATH

Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature A. O. Langford (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.