S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 2 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5188

Registration District No. 146 | Primary Registration District No. 3026 | Registrar's No. 55

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1497 No. Osage Street (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community 18 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Independence (If outside city or town limits, write "RURAL") 4

(d) Street No. 405 South Spring Street (If rural, give location) 40

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME WILLARD ELTON GREEN

3. (b) If veteran, name war ----------

3. (c) Social Security No. ----------

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife .....

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

7. Birth date of deceased June (Month) 4, (Day) 1868 (Year)

8. AGE: Years 79 | Months 7 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) N.Y. (State or foreign country) 2

10. Usual occupation 2

11. Industry or business .....

FATHER
12. Name No Data
13. Birthplace No Data (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name No Data
15. Birthplace No Data (City, town, or county) 9 (State or foreign country)

16. (a) Informant Bishop J.S. Kelley

(b) Address Independence, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/48 (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove Cemetery

18. (a) Signature of funeral director Roland R. Speaks

(b) Address Independence, Missouri

19. (a) 2-15-48 (Date received local registrar) (b) [signature] (Registrar's signature) 2541

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 13, year 1948 hour ..... minute ..... A.M.

21. I hereby certify that I attended the deceased from ..... 1940 to Feb 12 1948 that I last saw him alive on Feb 12 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Blindness resulting in fall on ice General debility.	2 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) accident 120

(b) Date of occurrence 2-12-48

(c) Where did injury occur? Independence, Mo. (City or town) (County) (State)

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

While at work? ..... (e) Means of injury 0

23. Signature John R. Green (M. D. or other)

Address Independence Mo. Date signed 2-14-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Roland R. Speaks

Licensed Embalmer No. 3604

P. O. Address Independence, Missouri

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, fact should be so stated above.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 55

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence
(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 years, months or days)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Willard E. Green

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 Mrd

6. (b) Name of husband or wife

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

7. Birth date of deceased June 4 1896
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 19 If less than one day hr. min.

9. Birthplace Whitney Point New York
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year 1948 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 — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY
no data

S-5188 1948