

No. 2  
 2-45  
 17-391  
 47070  
 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Registration District No. **150** Primary Registration District No. **55-72**

**1. PLACE OF DEATH:**  
 (a) County **Jackson**  
 (b) City or town **Rural Prairie**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **Jackson Co. Emergency Hospital**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **46 days**  
 (Specify whether years, months or days) **50 years**

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Independence** **118**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **511 S. Osage** **4**  
 (If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No) **4**  
 If yes, name country **1**

**3. (a) PRINT FULL NAME** **MELISSA J. GREEN**  
**3. (b) If veteran,** name war **none**  
**3. (c) Social Security** No. **2**  
**4. Sex** **Female** **5. Color or race** **wh.**  
**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** **July 30 1872**  
 (Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **May** day **6**  
 year **1948** hour **4** minute **45** P.M.  
**21. I hereby certify that I attended the deceased from** **Mar 30**  
**1948** to **May 6** **1948**  
 that I last saw her alive on **May 6** **1948**  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years **75** Months **9** Days **6** If less than one day hr. min.  
**9. Birthplace:** **Pittsburg Kansas**  
 (City, town, or county) (State or foreign country)  
**10. Usual occupation:** **Housewife**  
**11. Industry or business:**  
**12. Name:** **Isaac Ross**  
**13. Birthplace:** **Trenton Tennessee**  
 (City, town, or county) (State or foreign country)  
**14. Maiden name:** **Emma Dack**  
**15. Birthplace:** **Canada**  
 (City, town, or county) (State or foreign country)

Immediate cause of death **Coronary heart disease** **yes**  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
**Major findings:** **9/4/48**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
**16. (a) Informant:** **Kathryn Dook**  
**(b) Address:** **805 N. Dodgion Ind. Mo**  
**17. (a) Burial, cremation, or removal:** **Burial** (b) Date thereof: **5-8-48**  
 (Month) (Day) (Year)  
**(c) Place: burial or cremation:** **Mound Grove Cem**  
**18. (a) Signature of funeral director:** **George Carson**  
**(b) Address:** **Independence Mo**  
**19. (a) 5-7-480** (b) **Donald C. Earnest**  
 (Date received local registrar) (Registrar's signature)

**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) (e) Means of injury **Car**  
**Jack E. Richards**  
 Address **Indep., Mo.** Date signed **5/6/48**

**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..... *R.A. Lisle*.....  
.....  
..... Licensed Embalmer No. *4123*.....

P. O. Address *Indianapolis, 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, fact should be so stated above.**

Registration District No. 150

Primary Registration District No. 0572

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson  
(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

3. (a) PRINT FULL NAME Melissa J. Green

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

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

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

7. Birth date of deceased July 30 (Month) (Day) (Year)

8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. min.)

9. Birthplace Kansas (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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 5-7-78 (b) Donald C. Evans  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1978 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_ 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 \_\_\_\_\_

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. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-16625