

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 30 1949

2988

BIRTH NO. 41862-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 12 hours		d. STREET ADDRESS (If rural, give location) 8606 Independence Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital 0			

3. NAME OF DECEASED (Type or Print)		a. (First) Marchia	b. (Middle) De	c. (Last) GREEN	4. DATE OF DEATH (Month) (Day) (Year) July 7, 1949	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) new born 0		8. DATE OF BIRTH July 7, 1949	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Years - - -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Kansas City, Missouri 0		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Robert V. Green		13b. MOTHER'S MAIDEN NAME Lela Antoinette Fairchild		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Robert Green, 8606 Independence, K.C., Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 6 mo. post op - pulmonary atelectasis		ANTECEDENT CAUSES				
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Medical diabetes				
		DUE TO (c) Waters pre-eclampsia				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7696		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7 7 49 10²⁰ A.M.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 7, 1949, to July 7, 1949, that I last saw the deceased alive on July 7, 1949, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Richard B. Schultz, M.D. (Degree or title)) Richard B. Schultz M.D.		23b. ADDRESS 411 Canada St.		23c. DATE SIGNED July 9 1949	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-9-49		24c. NAME OF CEMETERY OR CREMATORY Forest Hill		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
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DATE REC'D BY LOCAL REG. 7-9-49		REGISTRAR'S SIGNATURE Heraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar, Kansas City, Mo.		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Schuster

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 _____

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed Oliver E. Heck

Licensed Embalmer No. 4063

P. O. Address K. 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, fact should be so stated above.