

FILED JUN 28 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18319**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **71** PRIMARY REG. DIST. NO. **3012** Registrar's No. **64**

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY <b>CLINTON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>EXCELSIOR SPRINGS</b>		c. CITY OR TOWN <b>LATHROP</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>EXCELSIOR SPRINGS Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>(Lathrop Township)</b> <b>0251</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>JEROME</b> b. (Middle) <b>WALTER</b> c. (Last) <b>GREEN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 10-1954</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN. 22-1874</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Clinton County Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>

13a. FATHER'S NAME <b>James H. Green</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Moore</b>	14. NAME OF MARRIAGE OR WIFE <b>May Green Lathrop, Mo.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. May Green Lathrop, Mo.</b>	ADDRESS <b>Lathrop, Mo.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>  <b>10 yrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis &amp; Anemically Induced</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Senile Arteriosclerosis</b> DUE TO (c)		
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 <b>4221</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <b>Excelsior Springs Clay Mo</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 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 **Sept**, 1953, to **JUNE 10 1954**; that I last saw the deceased alive on **June 9**, 1954, and that death occurred at **12 noon**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert Buchler MD</b>	23b. ADDRESS <b>Lathrop, Mo.</b>	23c. DATE SIGNED <b>6/12/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>6-12-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lathrop Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Lathrop Mo.</b>
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DATE REC'D BY LOCAL REG. <b>6/12/54</b>	REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>	62-0	25. FUNERAL DIRECTOR'S SIGNATURE <b>De Moss Crunk</b>	ADDRESS <b>Cameron, Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed *Harold L. Walker*.....

Licensed Embalmer No. *45*.....

P. O. Address *Lathrop*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.