

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 23 1955

State File No. **26176**
3526

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3526</u>		
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 town or township) Kansas City		c. LENGTH OF STAY (in this place) 20 Yrs.		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital # 1				e. STREET ADDRESS (If rural, give location) 1834 E. 7th St. 3170				
3. NAME OF DECEASED (Type or Print) a. (First) Vergie			b. (Middle) Delee		c. (Last) Green		4. DATE OF DEATH (Month) (Day) (Year) Aug. 10 55	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 30 March 1880		9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 2 Hrs. Hours	IF UNDER 15 Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) Ark.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Chester A. Green			
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS C.A. Green 1834 E. 7th. K.C. Mo.				
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Undetermined Pulmonary congestion + edema						INTERVAL BETWEEN ONSET AND DEATH	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) post-operative gastrostomy		DUE TO (c) Esophageal Varix - Cirrhosis of liver		5810	
	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				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) 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 <u>Aug. 3</u> , 19 <u>55</u> , to <u>Aug. 10</u> , 19 <u>55</u> , that I last saw the deceased <input checked="" type="checkbox"/> alive on <u>Aug. 10</u> , 19 <u>55</u> , and that death occurred at <u>2:15 am.</u> , from the causes and on the date stated above.								
23a. SIGNATURE B.I. Burns (Degree or title) M.D.				23b. ADDRESS 24th & Cherry Sts.		23c. DATE SIGNED 8/10/55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12 August-55	24c. NAME OF CEMETERY OR CREMATORY Floral Hills		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.			
DATE REC'D BY LOCAL REG. 8-11-55		REGISTRAR'S SIGNATURE Neva Minshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Floral Hills Memorial Chapels K.C. Mo.				

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

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 *Boyd C. McCall*.....

Licensed Embalmer No. *485*

P. O. Address *7 C*

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.