

Health,
Welfare
Public
Service

300
-57

All diseases in Part I must be causally related.
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032699

STATE FILE NUMBER

FILED OCT 15 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4530

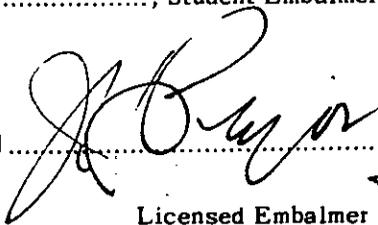
1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. INSIDE LIMITS Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital		d. STREET ADDRESS (If outside, give location) 2315 Cleveland	
Length of stay in hospital 6 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DALE LEE Green			4. DATE OF DEATH Month Day Year Sept 25 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1938
10a. USUAL OCCUPATION (Give nature of work done during most of working life, even if retired) Shipping Dept. - Clothing		10b. KIND OF BUSINESS OR INDUSTRY Lewald Mfg. Co.	11. BIRTHPLACE (City and state or country) West Liberty, Ill.
13a. FATHER'S NAME Ralph Green		13b. MOTHER'S MAIDEN NAME Lillian Hanson	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) Yes 2/55 - 1/57		16. SOCIAL SECURITY NO. 493-38-8314	17. INFORMANT Address Ralph Green - 1725 Virginia - Joplin, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull + DUE TO (b) Massive epidural hemorrhage DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Town car collision		
20c. TIME OF INJURY Hour Month, Day, Year 5:14 p.m. 9-24-58	20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Street		
20e. CITY, TOWN, OR LOCATION Kansas City, Missouri		20f. COUNTY STATE Jackson Mo	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dwight Boalff M.D. Deputy Coroner		22b. ADDRESS 6627 Prospect Blvd	22c. DATE SIGNED 9-25-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-26-58	23c. NAME OF CEMETERY OR CREMATORY Ozark Memorial Cemetery	23d. LOCATION (City, town, or county) (State) Joplin, Mo.
24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar 1800 Linwood		25. DATE RECD. BY LOCAL REG. 9-25-58	26. REGISTRAR'S SIGNATURE neva minshall



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 
Licensed Embalmer No. 2999

P. O. Address KC

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.