

FEB 17 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1813

1. PLACE OF DEATH

County Jasper Registration District No. 408 File No. _____
Township _____ Primary Registration District No. 3020 Registered No. _____
City Carthage (No. Stone Memorial Hospital) St. _____ Ward _____

2. FULL NAME Dennis Nelson Green

(a) Residence, No. _____ St. _____ Ward. Carl Jct. Mo.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred — yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 24 - 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 1 27

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carthage, Mo.

FATHER
13. NAME Ben E. Green

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maas, Crystal Mo.

MOTHER
15. MAIDEN NAME Crystal Holland

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Savanne, Mo.

17. INFORMANT Ben E. Green (ADDRESS) Carl Jct. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Carl Jct. Mo. DATE Jan 24 1937

19. UNDERTAKER (ADDRESS) C. P. Royer Carl Jct. Mo.

20. FILED Jan 24 1937 S. B. Chilton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21 1937 *Dr. Albert B. Wheeler*

22. I HEREBY CERTIFY that I attended deceased from Jan 17 1937 to Jan 21 1937
I last saw him alive on Jan 21 1937 Death is said to have occurred on the date stated above, at 10:20 a.m.

The principal cause of death and related causes of importance were as follows:

Toxemia Date of onset _____

Other contributory causes of importance:

Euphyemia

Name of operation None Date of _____

What test confirmed diagnosis? Def. Mortem Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) Albert B. Wheeler
(Address) Carthage, Mo.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1. PLACE OF DEATH

County Waskar Registration District No. _____
 Township Carthage Primary Registration District No. _____
 City Carthage (No. Stone, Mem. Hosp.) St. _____ Ward _____
 Registered No. 1873

2. FULL NAME

Dennis M. Green
 (a) Residence, No. Carl Junction, Mo. St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8
(Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE 2 YEARS MONTHS 1 DAYS 27 If LESS than 1 day, . hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE DATE 19__

19. UNDERTAKER (ADDRESS)

20. FILED _____, 19__

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 21 - 1937

22. I HEREBY CERTIFY That I attended deceased from _____, 19__, to _____, 19__

I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Tuberculosis Date of onset _____

Other contributory causes of importance:
Empyema
Unknown
Lobar pneumonia

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19__
 Where did injury occur? _____
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify Albert B. Wheeler M. D.
 (Signed) Carthage, Mo.
 (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE NECESSARY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-1813