

REC'D APR 10 1939

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

11679
Do not use this space.

1. PLACE OF DEATH 2
 (a) County New Madrid Registration District No. 625
 (b) Township Cross Primary Registration District No. 4359 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 1054 Ida Jane Greenlee
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C. W. Greenlee
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 15 1869
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 5 9
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Shuf
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 24 1939
 22. I HEREBY CERTIFY, That I attended deceased from Aug, 1938, to Mar 24, 1939
 I last saw her alive on Mar 21, 1939. Death is said to have occurred on the date stated above, at 9:29 a.m.
 The principal cause of death and related causes of importance were as follows:

Cardiac decompensation Date of onset _____
95 yr
 Other contributory causes of importance:
Old age

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ida
 FATHER 13. NAME Harvey Lacy
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ida
 MOTHER 15. MAIDEN NAME Woods
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 17. INFORMANT C. W. Greenlee
 (ADDRESS) Greenlee 276
 18. BURIAL, CREMATION, OR REMOVAL PLACE Madison DATE 3-26, 1939
 19. FUNERAL DIRECTOR (NAME) Crain
 (ADDRESS) Madison 278
 20. FILED 3/26 Dr. C. W. Greenlee
 Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis Chemical 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?
 If so, specify _____
 (Signed) Dr. C. W. Greenlee, M. D.
 (Address) Madison 278
534

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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.