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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30316

REC'D SEP 15 1939

Registration District No. 796 Primary Registration District No. 3038 Registrar's No. 138

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 520 E. Washington (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Marshall (If outside city or town limits, write "RURAL")
(d) Street No. 520 E. Washington (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Eli Green 651
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 1/31/1867 (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 10 If less than one day hr. min.

9. Birthplace Saline Co (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Eli Green
13. Birthplace Saline Co. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sterling Green
(b) Address 520 E. Washington
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-39 (Month) (Day) (Year)
(c) Place: burial or cremation Fair View
18. (a) Signature of funeral director Reuben Robinson
(b) Address 517 E. Washington
19. (a) 8-14-39 (Date rec'd by local registrar) (b) Mary Kent Dep (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11th
year 1939 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from 7-24-1939, to 8-11-1939; that I last saw him alive on 8-11-1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Endarteritis	39 / 7-24-8-11
Due to Chronic Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Amputation of leg 8-2-39
Of autopsy No

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. H. Webb (M. D. or other)
Address Marshall, Mo Date signed 8-14-39

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9/11/39

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~~ ....
Reuben Robinson ...., Registered Apprentice No. ....
working under my personal supervision.

Signed Reubin Robinson

Licensed Embalmer No. 2785

P. O. Address Marshall N

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.