

FILED AUG 16 1940

State File No. _____

Registrar's No. 166

Registration District No. 1

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Marshall, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Benton Sp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Amanda A Green ⁶⁵⁰

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James A. Green 6. (c) Age of husband or wife if alive 88 years
Birth date of deceased Apr 25 1853 (Month) (Day) (Year)

8. AGE: Years 87 Months 2 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Wife

11. Industry or business _____
12. Name Jonathan Grant
13. Birthplace Ohio (City, town, or county) (State or foreign country)
14. Maiden name Susan
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Green
(b) Address Marshall Mo R.F.D

17. (a) Burial (b) Date thereof June 28 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Highland Park

18. (a) Signature of funeral director William L. Plummer
(b) Address Marshall Mo

19. (a) July 26 40 (Date received local registrar) (b) Spencer L. Heenan (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Adair
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Benton Sp. (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1940 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 27 1940 to June 27 1940
that I last saw her alive on June 27 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocardial degeneration
Due to _____
Due to _____

Other conditions: (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature E. T. Davis M.D. (M. D. or other) _____
Address Marshall Mo. Date signed 7/26

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 8-40-1638

Date Filed AUG 15 1940

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

W. C. Summers

Licensed Embalmer No.

2159

P. O. Address

Hicksville mo

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.