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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 16 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28051

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 980

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

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5
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1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Saint Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hour (Specify whether

In this community 10 years years, months or days)

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2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town Saint Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 926 Felix Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Mrs. Mary Jane Greenlee

3. (b) If veteran, name war —

3. (c) Social Security No. 495-09-6523

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband ~~or wife~~ Louis Greenlee

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased January (Month) 19 (Day) 1900 (Year)

8. AGE: Years 40 | Months 7 | Days 16 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife &

11. Industry or business Bertram Hotel

FATHER
12. Name Frank Welch
13. Birthplace Albany, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Mary Frances Newman
15. Birthplace Albany, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Mrs. Bessie Pool

(b) Address 5618 South 3rd Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Albany, Missouri

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden F. Home

(b) Address 602 South 10th Street

19. (a) 9/7/40 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5th year 1940 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 6th, 1940 to Viewed, 19..., that I last saw h ######## alive on ....., 19..., and that death occurred on the date and hour stated above.

Immediate cause of death Suicide by taking Sodium Floride

Due to .....

Due to .....

Other conditions none (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy none

Duration

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) Suicide

(b) Date of occurrence Sept 5th 1940

(c) Where did injury occur? St Joseph (City or town) Mo. (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)

While at work? no (e) Means of injury 5

23. Signature B. W. Tadlock Coroner (M. D. or other) no

Address B. King Hill Bldg Date signed 9/6/40

(Licensed Embalmer's Statement on Reverse Side)

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, & by

Mollie E. Sidenfaden, Registered Apprentice No. 145

working under my personal supervision.

Signed R. V. West

Licensed Embalmer No. 3876

P. O. Address St. Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.