

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.

FILED SEP 16 1940

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

28154
Do not use this space.

1. PLACE OF DEATH

(a) County Candlen Registration District No. 117

(b) Township Osa ge Primary Registration District No. 0167 Registered No. 17

(c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(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 B. Green

(a) Residence, No. Candlen no. Rural (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 W. F. Green

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 3, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 3 3

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife

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 _____

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

FATHER

13. NAME Ed Francis

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

MOTHER

15. MAIDEN NAME Bell Laurie

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

17. INFORMANT (ADDRESS) Loyd F. Gunn

18. BURIAL, CREMATION, OR REMOVAL PLACE Rockdale Union Church DATE 10/8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Palmer's

20. FILED Sep 11, 1940 Jimmie Miller Apical Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 24, 1933 to Oct 6, 1939

I last saw him alive on about July 1, 1939. Death is said to have occurred on the date stated above, at 7:30 p.m.

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

Hypertension
Coronary occlusion

Date of onset unknown

Other contributory causes of importance: 4412

Name of operation none Date of _____

What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: 2

Accident, suicide, or homicide? 2 Date of injury 1939

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) A. J. Gunn M. D.

(Address) Verailles, Mo

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1289

Date Filed 9-10-40

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

S. P. Palmer

Licensed Embalmer No. 2208

P. O. Address Lebanon, 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.