

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

10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 23 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35468

Registration District No. 385

Primary Registration District No. 4228

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Willow Springs, 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 _____
(Specify whether in this community _____ years, months or days)

3. (a) PRINT FULL NAME CHARLES FRANKLIN GREEN

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

4. Sex Male 6. Color or race White
6. (a) Single, widowed, married, divorced Divorce
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased sept. 9 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 1 20 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Phillip Green

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Polly

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Elmer Green

(b) Address Willow Springs, Mo.

17. (a) Burial (b) Date thereof Oct. 30, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine Grove

18. (a) Signature of funeral director T.R. Burns

(b) Address Willow Springs, Mo.

19. (a) 10-30-40 (b) Mabelle Ferguson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29
year 1940 hour 6:00 minute PM

21. I hereby certify that I attended the deceased from 10-21-1940 to 10-29-1940
that I last saw him alive on 10-28-1940
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 4 days

Due to _____
Due to _____

Other conditions Cerebral Hemorrhage 10-21-40
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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

23. Signature C.F. Callahan (M. D. or other) _____
Address Willow Springs, Mo. Date signed 10/30/40

RECEIVED

District Health Officer No. 5

District File Number 1170.1108

Date Filed _____

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.....

Thomas R. Burns, Jr......, Registered Apprentice No. 251
working under my personal supervision.

Signed T.R. Burns.....

Licensed Embalmer No. 1847.....

P. O. Address Willow Springs, 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.

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Registration District No. 385-

Primary Registration District No. 4228

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

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Willow Springs
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Chas Franklin Green

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 20 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Philip Green
13. Birthplace _____ (City, town, county) (State or foreign country)
14. Maiden name Miss Okey
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant E
(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-30-40 (b) Nanette Ferguson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH Month Oct day 29
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
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 C. F. Callihan (M. D. or other) _____
Address Willow Springs Mo. Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH SUPPLEMENTAL COPY

