26345

S. No. 2
-11-10-39
5-17-39
P L X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 9 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 806 Primary Registration District No. 6051 Registrar's No.

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

8
0
0

1. PLACE OF DEATH:

(a) County Schyler Prairie Twp

(b) City or town Unionville (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 9 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schyler 98

(c) City or town Queen City (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.? 0 years.

3. (a) PRINT FULL NAME Ebenezer M. Green

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race Ar

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2

6. (b) Name of husband or wife —

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

7. Birth date of deceased Jan (Month) 8 (Day) 1859 (Year)

8. AGE:

Years	Months	Days	If less than one day
82	7	15	hr. min.

9. Birthplace (City, town, or county) 1 Fen (State or foreign country)

10. Usual occupation Merchant

11. Industry or business —

FATHER
12. Name Jessie Green
13. Birthplace (City, town, or county) 1 Fen (State or foreign country)

MOTHER
14. Maiden name Mary Walenberger
15. Birthplace Dent Kyrow (City, town, or county) 9 (State or foreign country)

16. (a) Informant A. G. Green

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-41 (Month) (Day) (Year)

(c) Place: burial or cremation Inexico Mo

18. (a) Signature of funeral director C. A. Hopper

(b) Address Clarence Mo.

19. (a) 7-24-41 (Date received local registrar) (b) Olive B Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1941 hour 8 minute 35 A M.

21. I hereby certify that I attended the deceased from July 6 Aug, 1940 to Aug, 1940 that I last saw h alive on Aug, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
1 Senility	2 yr
Due to	
Due to	
Other conditions Gen Senility (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. O. Coffey (M. D. or other) 0

Address Queen City Mo Date signed 7-24 1941

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-41-1425
Date Filed AUG 6 1941

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 Jack Hayes

Licensed Embalmer No. 3699

P. O. Address.....

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.

No. 2B
-8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26345

Registration District No. 806 Primary Registration District No. 6051 Registrar's No.

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Downs City Rural
(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 years, months or days)

In this community 3 yrs

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME

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 Widowed

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 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address Osgood - Mo.

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-24-41 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 23 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw him alive on 19;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY