

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11506

State File No. _____

FILED APR 12 1944
Registration District No. 270

Primary Registration District No. 5776

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Mercur

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

(c) Name of hospital or institution Washington Turn
(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 All his life

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 65th

(c) City or town _____ Mo
(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 Benn. J. Green

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th
year 1944 hour 8 minute 40 P.M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Clara Green

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased: Dec 26 1860
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 7 1944 to March 9 1944
that I last saw him alive on 9th of the month 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months _____ Days _____ If less than one day
hr. _____ min. _____

Immediate cause of death Coronary Occlusion of r.v.h.

Due to _____

Due to _____

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

10. Usual occupation Farmer

Other conditions 940
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name William Green

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

14. Maiden name Wright

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Nella Baumel

(b) Address 2317 Spruce St. Mo.

17. (a) Burial (b) Date thereof March 11, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mill Grove

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? _____

18. (a) Signature of funeral director Neil Mass

(b) Address Princeton Mo

19. (a) 3-10-44 (b) Edgar Martin
(Date received local registrar) (Registrar's signature)

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

23. Signature [Signature] M.D. or other _____
Address Princeton Mo Date signed 3/10/44

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

MOTHER FATHER

1367

(Licensed Embalmer's Statement on Reverse Side)

3/10/44

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 *me*

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Paul Mass*

Licensed Embalmer No. *2634*

P. O. Address *Sumner Me*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 24-

Registration District No. 210

Primary Registration District No. 5776

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

1. PLACE OF DEATH:

(a) County Mercer

(b) City or town Mill Grove
(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 Ben J 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 m

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

7. Birth date of deceased Dec 26
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 22 (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mercer

(c) City or town Mill Grove Mo
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1944 hour _____ minute _____ M.

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

Duration

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 _____

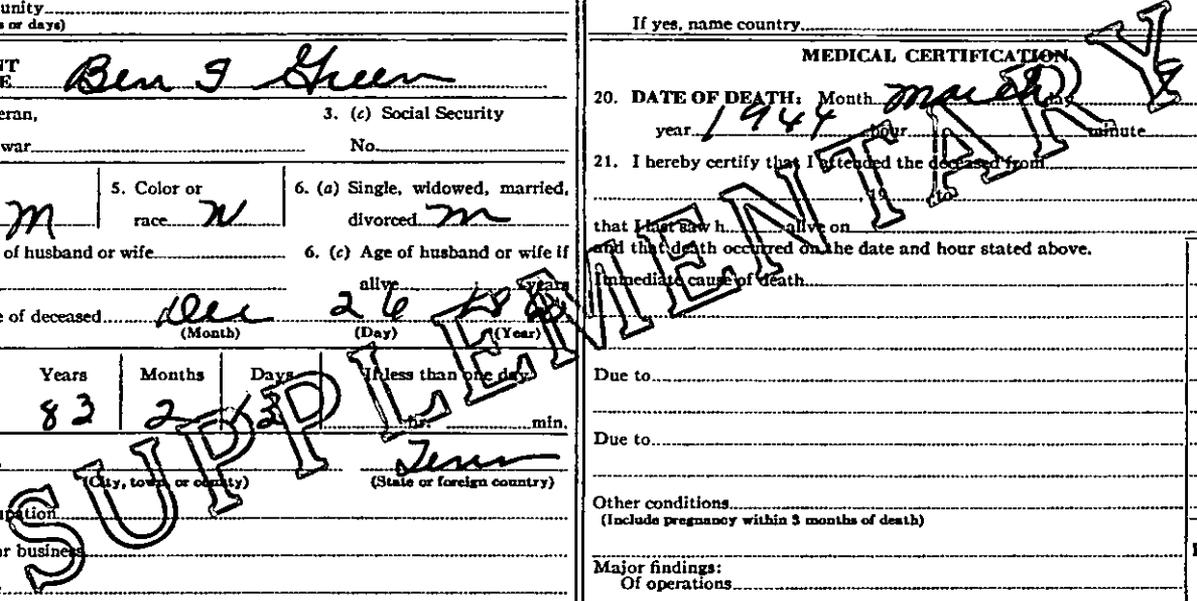
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) 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 _____



11506