

FILED SEP 14 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27195

State File No.

Registrar's No. 200

Registration District No. 38

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 38 days
(Specify whether
In this community.....
years, months or days) -

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory 43
(c) City or town Hermitage
(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 1

3. (a) PRINT FULL NAME Thomas Marshall Green

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

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

7. Birth date of deceased Sept 18 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days - If less than one day
hr. min.

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

10. Usual occupation Farmer, Blacksmith

11. Industry or business

12. Name Jasper Green

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

14. Maiden name Martha Ann Jackson

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

16. (a) Informant P. (Thomas M. Green)

(b) Address Hermitage, Mo.

17. (a) Burial (b) Date thereof Aug 21 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hermitage Mo

18. (a) Signature of funeral director R. Oliveira

(b) Address Columbia, Mo.

19. (a) 8-20-44 (b) Edna H Barber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
year 1944 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 12
1944, to August 19, 1944;

that I last saw him alive on August 19, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism

Due to Thrombus in femoral vein

Due to

Other conditions Ca. Sigmoid
(Include pregnancy within 3 months of death) 2 2/3 yrs.

Major findings: Ca. of Sigmoid

Of autopsy H&E

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 1
23. Signature J. L. Mayfield M.D. (M. D. or other)
Address..... Date signed 9/19/44

Duration 7 yrs
base

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

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

0
2
4

RECEIVED

District Health Officer No. 9

District File Number

Date Filed 9-13-44

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

Signed.....

Licensed Embalmer No. 3183

P. O. Address Columbia 24

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.