

S. No. 2
M-8-43
v. 5-17-39
X37823

27723

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 12 1946

State File No. _____

Registration District No. 199

Primary Registration District No. 4311

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Macon

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

(c) Name of hospital or institution: 1
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County macon

(c) City or town callao
(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 _____

3. (a) PRINT FULL NAME GREEN PATRICK, SR.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 31 year 1946 hour 6 minute 30 A-M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) _____ (Year) _____

7. Birth date of deceased 1 17 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 1st 1946 to Aug 31st 1946 that I last saw him alive on Aug 28th 1946 and that death occurred on the date and hour stated above.

8. AGE: Years 95 Months 8 Days 14 If less than one day hr. _____ min. _____

Immediate cause of death Senile Disability Duration 3yr

Due to _____

Due to _____

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

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

10. Usual occupation Retired Farmer

11. Industry or business Farming

12. Name Hesekiah Patrick

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

14. Maiden name Sally Roan

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

16. (a) Informant Mrs Catherine Stricklin
(b) Address Callao Missouri

17. (a) Burial (b) Date thereof 9-2-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hebron cemetery

18. (c) Signature of funeral director W. Edwards
(b) Address Bevier Mo

19. (a) Sept 6 1946 (b) W. J. Allen
(Date received local registrar) (Registrar's signature)

Major findings: Of operations no

Of autopsy no

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) (e) Means of injury fall

23. Signature W. J. Allen (M. D. or _____)
Address New Pointe Mo Date signed Aug 31 1946

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

20501

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 *J. S. Edwards*
Licensed Embalmer No. 1961
P. O. Address Brewer 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, fact should be so stated above.

RECEIVED
District Health Officer No. 10
District File Number 9-46-1722
Date Filed SEP 11 1946