S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27023

FILED SEP 2 1948

Registration District No. 289

Primary Registration District No. 3043

Registrar's No. 276

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Levering Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 28 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Monroe 69
(c) City or town Stoutsville 0
(If outside city or town limits, write "RURAL")
(d) Street No. — 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Ann Mae Green
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Pearl E Green
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased May (Month) 12 (Day) 1888 (Year)

8. AGE: Years 60 ~~60~~ Months 3 Days 14 If less than one day ..... hr. ..... min.

9. Birthplace Stoutsville (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation at Home
11. Industry or business
FATHER
12. Name George W. Thompson
13. Birthplace Stoutsville (City, town, or county) Missouri (State or foreign country) 0
MOTHER
14. Maiden name Fannie Poague
15. Birthplace Stoutsville (City, town, or county) Missouri (State or foreign country) 0
16. (a) Informant P E Green
(b) Address Stoutsville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28-48 (Month) (Day) (Year)
(c) Place: burial or cremation Stoutsville Cemetary
18. (a) Signature of funeral director Wilson & Son's
(b) Address Monroe City Missouri
19. (a) Aug 28 48 (Date received local registrar) (b) Dr E M Lucke (Registrar's signature) 184

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26
year 1948 hour 4 minute 15 A. M.
21. I hereby certify that I attended the deceased from Aug 1 1948 to Aug 26 1948
that I last saw him alive on Aug 26 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Cocanomatous
Due to Primary in bowel
Due to
Other conditions Cachexia
(Include pregnancy within 3 months of death)
Major findings:
Of operations 46 E
Of autopsy

Duration

PHYSICIAN
Underline the cause of 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 [signature] (M.D. or other)
Address 100 Bldg Hannibal Mo Date signed 8/28/48

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Charles V. Greening Registered Apprentice No. 214 working under my personal supervision.

Signed Leslie L. Nelson

Licensed Embalmer No. 3014

P. O. Address Monroe City 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.

S. No. 2B
M—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 22 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 276

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(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

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 Anna Mae Green

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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

7. Birth date of deceased May 12 (Month) (Day) (Year)

8. AGE: Years 60 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 26 year 1948 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	Duration
Due to	
Ca of Sigmoid	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. H. Kerk (M. D. or other)

Address Date signed

SUPPLEMENTARY

1948
27023