

FILED MAR 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5526

BIRTH NO. <i>120</i>		REG. DIST. NO. <i>241</i>		PRIMARY REG. DIST. NO. <i>5828</i>		Registrar's No. <i>11</i>	
1. PLACE OF DEATH a. COUNTY <i>New Madrid</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>New Madrid</i>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Rural - Point Pleasant</i>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Le Sueur</i>		d. STREET ADDRESS (If rural, give location) <i>0720</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>8 miles E. of Portageville</i>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <i>Carrie</i> b. (Middle) <i>Lee</i> c. (Last) <i>Green</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>Feb 11, 1950</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Black</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>abt 1932</i>		9. AGE (In years last birthday) <i>18</i>	IF UNDER 1 YEAR Months   Days	IF UNDER 2 HRS. Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>hwt</i>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <i>West Point, Miss</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13a. FATHER'S NAME <i>John Usher</i>		13b. MOTHER'S MAIDEN NAME <i>Josie Taylor</i>		14. NAME OF HUSBAND OR WIFE <i>Leslie B. Green</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>William Valliant - Point Pleasant Mo</i>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Shot on right side of body</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>with 22 rifle and went through body to just under skin of left side, hitting heart</i> DUE TO (c) <i>through body to just under skin of left side, hitting heart</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>Dont know</i>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <i>Le Sueur New Madrid Mo</i>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>2/11/50 9:30 a.m.</i>		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Shot with 22 rifle E9360 23</i>						
22. I hereby certify that I attended the deceased from <i>2/11/50</i> , 19 <i>50</i> , to <i>2/11/50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2/11/50</i> , 19 <i>50</i> , and that death occurred at <i>9:30 a.m.</i> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Leo Hedgcock, 3 Coroner</i>			23b. ADDRESS <i>New Madrid Mo</i>			23c. DATE SIGNED <i>2/11/50</i>	
24a. BURIAL, CREMATION, REMOVAL <i>Removal</i>	24b. DATE <i>Feb 11, 1950</i>	24c. NAME OF CEMETERY OR CREMATORY <i>?</i>		24d. LOCATION (City, town, or county) (State) <i>West Point, Miss</i>			
DATE REC'D BY LOCAL REG. <i>Feb 11, 1950</i>	REGISTRAR'S SIGNATURE <i>Ellen DeLisle 219</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Caston Funeral Home - Blytheville, Ark</i>				

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

RECEIVED FEB 23 1950  
District Health Office No. 2  
District File Number 250-145  
Date Filed \_\_\_\_\_

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.