

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29977**

FILED OCT 1 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 808

396

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

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Willard</b> <b>0390</b>	
c. LENGTH OF STAY (If in hospital or institution) <b>4 Months</b>		d. STREET ADDRESS (If rural, give location) <b>/</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>734 East Madison St</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Robert</b>	b. (Middle) <b>Lee</b>	c. (Last) <b>Greenwade</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 20, 1951</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 25, 1868</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR <b>2</b> Months <b>25</b> Days	IF UNDER 4 HRS. <b></b> Hours <b></b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Funeral Director</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Undertaker</b>	11. BIRTHPLACE (State or foreign country) <b>Willard, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>John T. Greenwade</b>	13b. MOTHER'S MAIDEN NAME <b>Ruhama Pugh</b>	14. NAME OF HUSBAND OR WIFE <b>Ethel Watson Greenwade</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs E.W. Greenwade,</b>	ADDRESS <b>Willard, Mo</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) <b></b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Parkinsons Disease</b>		<b>5 years</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>3-3-2 X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1945 to Sept 20, 1951 that I last saw the deceased alive on Sept 20, 1951 and that death occurred at 10:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE <b>Henrieth O. Coffey M.D.</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Springfield, Mo.</b>	23c. DATE SIGNED <b>Sept 22, 1951</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept 25, 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Wesley's</b>	24d. LOCATION (City, town, or county) (State) <b>Near Willard, Mo</b>
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DATE REC'D BY LOCAL REG. <b>9-25-51</b>	REGISTRAR'S SIGNATURE <b>W. E. Handley WDO</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Greenwade-Windle,</b>	ADDRESS <b>Willard, Mo</b>
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Dr. Cog  
morton

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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 James W. Warr

Licensed Embalmer No. 4650

P. O. Address Springfield, ma

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.