

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19827

State File No.

FILED JUL 5 1952
BIRTH NO. _____ REG. DIST. NO. 69 PRIMARY REG. DIST. NO. 5272 Registrar's No. 15

0220

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

1. PLACE OF DEATH a. COUNTY <u>CHRISTIAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CHRISTIAN</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>"RURAL" POLK</u>	c. LENGTH OF STAY (In this place) <u>71 YRS.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>"RURAL" POLK</u> 0220 d	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RT # 2, BILLINGS</u>		d. STREET ADDRESS (If rural, give location) <u>RT # 2, BILLINGS</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>KATHERINE</u> b. (Middle) <u>MARY</u> c. (Last) <u>GREEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 28 1952</u>
---	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED 1</u>	8. DATE OF BIRTH <u>APRIL 30-1877</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days	IF UNDER 18 HRS. Hours Min.
----------------------	-------------------------------	---	---------------------------------------	---	----------------------------------	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>DOYLESTOWN - OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
--	-----------------------------------	--	--

13a. FATHER'S NAME <u>ANTHONY FABRO</u>	13b. MOTHER'S MAIDEN NAME <u>ROSA KNORLESPIEZ</u>	14. NAME OF HUSBAND OR WIFE <u>MATHIAS GREEN</u>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MATHIAS GREEN</u> ADDRESS <u>RT # 2, BILLINGS, MO.</u>
---	-------------------------------------	---

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4500</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	--	--

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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from May, 1950, to June, 1952, that I last saw the deceased alive on 14 June, 1952, and that death occurred at 5:05 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Karl Leidinger M.D. - C</u>	23b. ADDRESS <u>Republic, MO</u>	23c. DATE SIGNED <u>7-1-52</u>
---	----------------------------------	--------------------------------

24a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JULY 1-1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S CATHOLIC</u>	24d. LOCATION (City, town, or county) (State) <u>CHRISTIAN Co., MO.</u>
---	------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>July 1, 1952</u>	REGISTRAR'S SIGNATURE <u>Alvin Brewer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John Dean Harris</u> ADDRESS <u>Clever, Mo.</u>
--	---	---

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.....

John Dean Harris

Licensed Embalmer No. 4390

P. O. Address Cleves, 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.