

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

7509

State File No.

FILED MAR 9 1954

BIRTH NO. _____ REG. DIST. NO. **339** PRIMARY REG. DIST. NO. **16149** Registrar's No. **53**

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Stoddard	
b. CITY OR TOWN Bloomfield, R-1	c. LENGTH OF STAY (in this place) 5 1/2 yrs	c. CITY OR TOWN Bloomfield R-1	1030
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If rural, give location) North view	

3. NAME OF DECEASED (Type or Print) BESSIE a. (First) May b. (Middle) GREEN c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Feb 7 1954		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 5 1882	9. AGE (In years last birthday) 71	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 2 WKS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Galena Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John W. Shipman	13b. MOTHER'S MAIDEN NAME Laura Texas	14. NAME OF HUSBAND OR WIFE John A. Green
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME John A. Green	ADDRESS Bloomfield R-1
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 da.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Gastro-enteritis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) De generative myocarditis DUE TO (c) Arteriosclerosis		
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 4221	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) Stoddard Co. MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 2-5 1954, to 2-7, 1954, that I last saw the deceased alive on 2-5, 1954, and that death occurred at 10 A. m., from the causes and on the date stated above.

23a. SIGNATURE S. S. Davis (Degree or title) D.M.D.	23b. ADDRESS Wester View	23c. DATE SIGNED 2-12-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb 9 - 1954	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	24d. LOCATION (City, town, or county) (State) Stoddard Co. MO
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DATE REC'D BY LOCAL REG. Feb. 14, 1954	REGISTRAR'S SIGNATURE Claudine Williams	447-1	25. FUNERAL DIRECTOR'S SIGNATURE Watkins Funeral Service	ADDRESS Bloomfield MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10.48

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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

Walter Marsh Watkins

Licensed Embalmer No.

4717

P. O. Address

Dexter, 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.