

FILED APR 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12352

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 4241 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Oak Grove		c. CITY (If outside corporate limits, write RURAL and give township) Oak Grove	
c. LENGTH OF STAY (in this place) 20ys		d. STREET ADDRESS (If rural, give location) City	
d. FULL NAME OF HOSPITAL OR INSTITUTION City			

3. NAME OF DECEASED (Type or Print) a. (First) James			b. (Middle) W			c. (Last) Greer			4. DATE OF DEATH (Month) (Day) (Year) April 5 1954		
5. SEX Male		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct 22 1881			9. AGE (In years last birthday) 73		10. MONTHS 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Labor				10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (City and State or Foreign Country) Dover Mo			12. CITIZEN OF WHAT COUNTRY? usa		

13a. FATHER'S NAME James M Greer			13b. MOTHER'S MAIDEN NAME Sarah Petty			14. NAME OF HUSBAND OR WIFE Rosa Belle Greer		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 500-03 9201		17. INFORMANT'S SIGNATURE OR NAME Rosa Greer, Oak Grove		ADDRESS Mo	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neurosis of Toes & heel of Both feet						INTERVAL BETWEEN ONSET AND DEATH 2 m	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetic metatars						1 yr	
		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 260X						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)	
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?	

22. I hereby certify that I attended the deceased from Oct, 1953, to April 5, 1954, that I last saw the deceased alive on April 5, 1954 and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE D Linton M.D.		(Degree or title)		23b. ADDRESS Oak Grove Mo		23c. DATE SIGNED 4-6-1954	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 7-1954		24c. NAME OF CEMETERY OR CREMATORY Oak Grove		24d. LOCATION (City, town, or county) (State) Oak Grove Mo	
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DATE REC'D BY LOCAL REG. 4-6-1954		REGISTRAR'S SIGNATURE H.B. Langsford		25. FUNERAL DIRECTOR'S SIGNATURE Webb Funeral Home		ADDRESS Oak Grove Mo	
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(Licensed Embalmer's Statement on Reverse Side)

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

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

R B Webb

Licensed Embalmer No. 2353

P. O. Address Blue Springs

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.