

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 017839

FILED JUN 12 1957

STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 241

Health, Welfare & Public Service
300
1-56
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MARCELINE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>108 E RITCHIE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FORREST</u> Middle <u>KENNETH</u> Last <u>GREENHALGH</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>1st</u> Year <u>1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1906</u>
9. AGE (In years last birthday) <u>50</u>		10. KIND OF BUSINESS OR INDUSTRY <u>HOTEL MANAGER</u>	11. BIRTHPLACE (City and state or country) <u>EVERIST, IOWA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM G. GREENHALGH</u>		14. MOTHER'S MAIDEN NAME <u>MARY BURDOCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>June 1942 - OCT. 1945</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address <u>MARCELINE, MO.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sulmonary Embolism -</u> <u>Streptococcal Hemuria</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>5615</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>May 23, 1957 - Surgery was done to the leg secondary to Hemuria & obstipation May 24, 1957 - Prostatectomy was done to relieve & remove obstr & infection</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>done to relieve & remove obstr & infection</u>
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
21. I attended the deceased from <u>May 23, 1957</u> to <u>6-1-57</u> and last saw her alive on <u>5-31-57</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James McLaughlin</u> (Degree or title)		22b. ADDRESS <u>Marceline, MO</u>	
22c. DATE SIGNED <u>6-1-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>JUNE 3, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST</u>	23d. LOCATION (City, town, or county) (State) <u>MARCELINE, MISSOURI</u>
24. FUNERAL DIRECTOR <u>McLAUGHLIN'S</u> ADDRESS <u>MARCELINE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-3-57</u>	26. REGISTRAR'S SIGNATURE <u>Brook Owens</u>

JUN 12 1957

JUN 24 1957

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 _____
Signature of Student Embalmer

Signed James B. McCalla

Licensed Embalmer No. 42

P. O. Address Brooklyn

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.