

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-004791
STATE FILE NUMBER

FILED MAR 4 - 1958

Registration District No. 61 Primary Registration District No. 5237 Registrar's No. 9

300
-57

1. PLACE OF DEATH a. COUNTY <u>Cedar</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Springs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>El Dorado Springs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt. #3</u>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Rt. #3</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarene Everett Green</u>				4. DATE OF DEATH Month Day Year <u>2-24-58</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-1907</u>		9. AGE (In years last birthday) <u>50</u>		10. UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>El Dorado Spgs., Mo. U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Arthur Green</u>				13b. MOTHER'S MAIDEN NAME <u>Dollie Stein</u>				14. NAME OF HUSBAND OR WIFE <u>Mable Green</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>no</u> ; if yes-give year or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>500-05-9062</u>		17. INFORMANT Address <u>Mable Green Rt. #3 - El Dorado Spgs 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>Carcinoma stomach</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO <u>with metastases to liver</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>ISIX</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>			
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.)										
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT <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>11-19-57</u> to <u>2-24-58</u> and last saw ^{her} _{him} alive on <u>2-24-58</u> Death occurred at <u>2-24-58 10:45 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Wm. B. Richter M.D.</u>						22b. ADDRESS <u>Stockton Mo</u>			22c. DATE SIGNED <u>2-25-58</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE <u>2-26-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Clintonville Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>El Dorado Springs, Mo.</u>					
24. FUNERAL DIRECTOR <u>Glenn Brothers El Dorado Spgs Mo</u>					ADDRESS <u>9-16-58</u>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>George W. Hefner</u>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

JAN 17 1963

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 *Max W. Dickering*

Licensed Embalmer No. *4696*
P. O. Address *E. D. ...*

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.