

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016575

STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. 369 Primary Registration District No. 2257 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <b>WAYNE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>MO.</b> b. COUNTY <b>WAYNE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>PATTERSON</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>PATTERSON</b> <sup>1110</sup>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		Length of stay in 1b <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>KING GOLDEN GREEN</b>			4. DATE OF DEATH Month Day Year <b>APR. 26 1959</b>			
--	--	--	---	--	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 14, 1874</b>	9. AGE (In years) <b>85</b>	IF UNDER 1 YEAR Month Day <b>3 12</b>	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	-----------------------------	---------------------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (City and state or country) <b>SACO MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	---	--	--

13a. FATHER'S NAME <b>ALFRED GREEN</b>	13b. MOTHER'S MAIDEN NAME <b>PRISHIA WILSON</b>	14. NAME OF HUSBAND OR WIFE <b>EMILY (STACY) GREEN</b>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>500-42-3178</b>	17. INFORMANT Address <b>JUAN GREEN PATTERSON, MO</b>
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial heart failure</b> <b>arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
---	--

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 <b>1950</b> to <b>4/24/59</b> and last saw <sup>him</sup> <sub>her</sub> alive on <b>4/24/59</b> Death occurred at <b>4:30</b> p on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <b>H. H. Green mdr</b> (Degree or title)	22b. ADDRESS <b>Piedmont, MO</b>	22c. DATE SIGNED <b>4-29-59</b>
---	----------------------------------	---------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/29/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PATTERSON (WOODS)</b>	23d. LOCATION (City, town, or county) (State) <b>PATTERSON MO</b>
--	----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <b>GISH FUNERAL HOME</b>	25. DATE RECD. BY LOCAL REG. <b>5-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Sheila Lovelace</b>
---	--	--

PIEDMONT, MO,

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 6 1959

1959

6

FILE NO. \_\_\_\_\_  
STATE OF MICHIGAN CENTER

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 *me*, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Marvin E. Bowler*

Licensed Embalmer No. 4426  
P. O. Address *Piedmont*

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.