

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959

42

59-035012

UNDECEASED

Registration District No. 373 Primary Registration District No. 6267373 Registrar's No. 6267

STATE FILE NUMBER 52

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JACKSON Twp.		Length of stay in 1b 25 YRS	c. CITY OR TOWN MARSHFIELD RI
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6 MI NW

3. NAME OF DECEASED (Type or print) First Middle Last CHAD HARMON GREER			4. DATE OF DEATH Month Day Year AUG 28 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-19-1903	9. AGE (last birthday) 55		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME ROBERT H. GREER		13b. MOTHER'S MAIDEN NAME ELLA HARMON		14. NAME OF DECEASED OR WIFE EDITH		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 499-14-0135	17. INFORMANT EDITH GREER MARSHFIELD RI	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Circulatory Failure		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) Coronary Thrombosis		
DUE TO (c) Arteriosclerosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 a.m. p.m. Month, Day, Year		
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 about 830 P to _____ and last saw her/him alive on _____
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. Edward Carone		22b. ADDRESS Marshfield Mo		22c. DATE SIGNED 8/29/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-1-1959	23c. NAME OF CEMETERY OR CREMATORY MISSION HOME	23d. LOCATION (City, town, or county) WEBSTER Co MO	(State)
24. FUNERAL DIRECTOR BARBER-EDWARDS		ADDRESS MARSHFIELD	25. DATE RECD. BY LOCAL REG. 9-16-59	26. REGISTRAR'S SIGNATURE J. J. Francis

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Robert Barber

Licensed Embalmer No. 3848

P. O. Address 11th Street

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.