

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-033560

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 160

FILED OCT 11 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>MACON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MACON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON</u> Length of stay in 1b		c. CITY OR TOWN <u>CALLAO MO</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>Taylor Rest Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES W. GREEN</u>			4. DATE OF DEATH Month Day Year <u>9-4-61</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 type="checkbox"/>	8. DATE OF BIRTH <u>2-12-24</u>
9. AGE (last birthday) <u>37</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>Chariton Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.C.</u>		13a. FATHER'S NAME <u>JAMES B. GREEN</u>	
13b. MOTHER'S MAIDEN NAME <u>Bene Dennis</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Wayne Green</u> Address <u>Padiso</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>congestive heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>
DUE TO (b) <u>prolonged recumbency and urinary sepsis</u>			unknown
DUE TO (c) <u>fracture of right hip</u>			2 months
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 type="checkbox"/>	20a. ACCIDENT <input checked="" 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>Patient fell in his room getting off bed.</u>	
20c. TIME OF INJURY Hour <u>7-1-61</u> Month, Day, Year <u>a.m.</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Taylor's Nursing Home</u>		20f. CITY, TOWN, OR LOCATION <u>Macon, Missouri</u>	COUNTY <u>Macon</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>1959</u> to <u>Sept. 1961</u> and last saw her/him alive on <u>September 2, 1961</u> . Death occurred at <u>11:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not print) <u>James L. Hudson, M.D.</u>		22b. ADDRESS <u>Macon, Missouri</u>	22c. DATE SIGNED <u>9-26-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Zion Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>CALLAO, MO</u>
24. FUNERAL DIRECTOR <u>Edwards</u> ADDRESS <u>Paris Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10/2/61</u>	26. REGISTRAR'S SIGNATURE <u>Keith M. Neely</u>	

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

J. S. Edwards

Licensed Embalmer No. 1961

P. O. Address Deerfield, Mo.

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.