

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023853

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 119 Primary Registration District No. 9192 Registrar's No. 29

FILED JUL 2 1963

VS 300  
Rev. 4/59

1 1370

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>GASCONADE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MORRISON</b>		Length of stay in 1b <b>3 Months</b>	c. CITY OR TOWN <b>MORRISON</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARLYLE B. GREEN</b>			4. DATE OF DEATH Month Day Year <b>June 21, 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Priest</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ministry</b>	9. AGE (last birthday) <b>53</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Rhodes W. Green</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Verhoff</b>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Elizabeth Green--Mexico, 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>Sudden death probably due to coronary occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>None</b>
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)			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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>H</b>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>7-20-60 only</b> , to _____ and last saw her/him alive on _____ Death occurred at <b>7:00 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Carroll T. Shaw, M.D.</b>		22b. ADDRESS <b>Hermann, Mo.</b>	22c. DATE SIGNED <b>6-21-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 25, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Martinsburg Mo</b>
24. FUNERAL DIRECTOR <b>Herman Blumer, Inc.--Hermann, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-29-63</b>	26. REGISTRAR'S SIGNATURE <i>Delma Uffelman</i>

JUL 8 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

*Oswald L. Geyer*

Licensed Embalmer No. 5187

P. O. Address Hermann, 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.