FEB 21 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. 1665

1. PLACE OF DEATH
County LACIEDE — Registration District No. 449 — File No.
Township OSAGE — Primary Registration District No. 3618 — Registered No. 1421
City ..... (No. ..... St. ..... Ward)

2. FULL NAME FERDENANDO GREENSTRET
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: PERMELIA LEDFORD

6. DATE OF BIRTH (MONTH, DAY AND YEAR): FEB. 7, 1849

7. AGE: 78 YEARS — MONTHS: 10 — DAYS: 27 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Old Soldier
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): FRANKLIN, CO.
(STATE OR COUNTRY): MO

PARENTS
10. NAME OF FATHER: CLAYTON
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): U.S.
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): " "
(STATE OR COUNTRY)

14. INFORMANT: E.G. Greenstreet
(Address): Lebanon R.7.

15. FILED 1/6, 1928 J. M. Billiard, REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 4th 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1927, to Jan. 4, 1927 that I last saw him alive on Dec. 1, 1928, and that death occurred, on the date stated above, at 2 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
131
82A
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY): Chronic Interstitial Nephritis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? [illegible]
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) H. A. Hamilton, M.D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Smith Cemetery — DATE OF BURIAL: 1-5 1928

20. UNDERTAKER: Palmer — ADDRESS: Lebanon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.