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

Do not use this space.

12020

1. PLACE OF DEATH
County Vernon Registration District No. 873 File No.
Township Washington Primary Registration District No. 6162 Registered No. 86
City ~~[illegible]~~ (No. St. Ward)

2. FULL NAME W. J. Greene
(a) Residence. No. State Hosp. #3 St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 4 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

3-8-4-11

30 [illegible]

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 22-1869

7. AGE: ✓ Years 59 Months 4 Days 10 If LESS than a day, hrs. or min.

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

9. BIRTHPLACE (CITY OR TOWN) Laclede Co. Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Frank Green
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn. D-12.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Nancy Stowe
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Green Co. Mo.
(STATE OR COUNTRY)

14. INFORMANT Anna Hall
(Address) Clever Mo.

15. FILED 4-10, 1928 E. R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 3 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct., 1928, to death, 1928, that I last saw him alive on Mar. 3, 1928, and that death occurred, on the date stated above, at 1 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis

S.D.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 7513

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? not known
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clin. + laboratory

(Signed) J. J. O'Dell, M.D.
Mar. 3, 1928 (Address) State Hosp. #8 Nevada Mo

*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: Clever Mo. DATE OF BURIAL: 3/4 1928

20. UNDERTAKER: Jenkins Nevada Mo ADDRESS

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Vernon — Registration District No. 875 — File No. .....

Township Washington — Primary Registration District No. 6162 — Registered No. 86

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME W. L. Greene

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-22-1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	58	4	11	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 5-11 1928 E. R. King
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 3 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., 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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—[illegible] of information should be carefully supp[illegible] should be stated EXACT[illegible] PHYSICIANS should state [illegible] in plain terms, so that it may be properly [illegible]. Exact statement of O[illegible] is very important.

SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE A[illegible] DESCRIBED BY LAW

5-12020