JAN 25 1929

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

Do not use this space.

41970

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Pemiscott — Registration District No. 656

Township: Cooter — Primary Registration District No. 5878

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

2. FULL NAME Betty. Green.

(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)
Female	White	

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	82	10	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER Unkown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unkown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT J. L. Bnys.
(Address) Holland. Mo/

15. FILED 1-10, 1929. James A Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-17-1928

17. I HEREBY CERTIFY, That I attended deceased from 12-10-1928, to 12-17, 1928, that I last saw her alive on 12-17, 1928, and that death occurred, on the date stated above, at 7.30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

~~Carcinoma of Cervix~~

11-18

(duration) 3 yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY) 116

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? x

DID AN OPERATION PRECEDE DEATH? no DATE OF x

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Sick. no

(Signed) L. E. Cooper, M. D

1-9-, 1929 (Address) Caruthersville, 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: No. '8 Cemetery

DATE OF BURIAL: 12-18 1928

UNDERTAKER: COBB UNDERTAKING CO

ADDRESS: Blytheville Ark

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.