

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

Do not use this space.

9421

PLACE OF DEATH

County Anderson
Township Sullivan
City Mexico Mo

Registration District No. 24
Primary Registration District No. 3002

File No. _____
Registered No. 42
St. _____ Ward) _____

2. FULL NAME Thomas James Green

(a) Residence No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 26 1929

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

17. I HEREBY CERTIFY That I attended deceased from March 14, 1929, to March 26, 1929 that I last saw him alive on March 25, 1929, and that death occurred, on the date stated above, at 1:00 P.M. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-20-1864
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 65 66 - 6

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis from acute suppurative appendicitis. Cholelithiasis.
(duration) yrs. mos. da.

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

CONTRIBUTORY (SECONDARY) Phlebitis, left leg.
(duration) yrs. mos. da.

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

18. WHERE WAS DISEASE CONTRACTED Vandalia, Mo IF NOT AT PLACE OF DEATH _____

10. NAME OF FATHER Wm Green

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 3/14/1929 WAS THERE AN AUTOPSY? no

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

WHAT TEST CONFIRMED DIAGNOSIS? Chieical findings (Signed) A. B. Clark, M. D.

12. MAIDEN NAME OF MOTHER Owens.

3/26, 1929 (Address) Mexico, Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

*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.

14. INFORMANT (Address) Willie Green
Louisiana

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Vandalia Mo 9-28-1929

15. March 28th 1929 Ira S. Milligan REGISTRAR

20. UNDERTAKER J. B. Clark Vandalia Mo ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. DO NOT SIGN ANYTHING UNLESS YOU ARE A PHYSICIAN.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Audrain Registration District No. 26 File No. 9421
Township _____ Primary Registration District No. 3002 Registered No. 42
City Mexico (No. _____) St. _____ Ward _____

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-20-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
65 - 6

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) _____

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. March 26th 1929 Ira S. Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 26 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, 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

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-9421