MAY 29 1929

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

Do not use this space.

16904

1. PLACE OF DEATH
County Saline — Registration District No. 796 — File No.
Township Marshall — Primary Registration District No. 6039 — Registered No. 78
City ~~Marshall Mo~~ (No. ..... St. ..... Ward)

2. FULL NAME Robert 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: Male
4. COLOR OR RACE: Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widower

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

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

7. AGE: 15 — YEARS: unknow — MONTHS: — DAYS: — If LESS than 1 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) (STATE OR COUNTRY): Virginia

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

14. INFORMANT: Mrs Hattie Talton
(Address) Marshall Mo

15. FILED 5-6, 1929 Mrs John H McGuire REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-29, 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 20th, 1929, to April 29, 1929, that I last saw him alive on 4-29, 1929, and that death occurred, on the date stated above, at 11 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Contused Wound caused by constant abration of shoe on foot (duration) yrs. 3 mos. 9 ds.

CONTRIBUTORY (SECONDARY) Septic Infection (duration) yrs. 1 mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1941 26
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? 0
(Signed) H H Webb, M. D
, 19 (Address) Marshall, 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: Carrollton Mo — DATE OF BURIAL: 5-1 1929

20. UNDERTAKER: Willis Bros — ADDRESS: Carrollton Mo

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.