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

Do not use this space.

JUL 26 1929

54

1. PLACE OF DEATH
County Layafette.
Township Freedom.
City ..... (No. ....., ... St. ..... Ward)

Registration District No. ~~460~~ 457 5621
Primary Registration District No. ~~5624-a~~

File No. 25078
Registered No. 46

2. FULL NAME Albert Warren 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)
Male	White	Widowed.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 4.1863.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	10	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Minister.
(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) Pike CO. ILL.

PARENTS
10. NAME OF FATHER Warren Green.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Pike. CO. ILL
12. MAIDEN NAME OF MOTHER Lucinda Taylor.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) ILL.

14. INFORMANT Mrs. J. R. Davis.
(Address) Allville, Mo.

15. FILED 7-6 1929 Dessie P Porter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 4, 1929 that I last saw him alive on June 28, 1929, and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82A
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 74A1
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH —
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) W. C. Webb, M. D.
July 4, 1929 (Address) Higginsville

*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
Jacoby Chapel Cemetery.	July.6 1929.

20. UNDERTAKER	ADDRESS
R. Q. Phillips. Warrensburg. 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.