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

Do not use this space.
31518

1. PLACE OF DEATH
County: Pemiscot
Township: Little Prairie
City: ..... (No. ....., ..... St., ..... Ward)
Registration District No.: 151
Primary Registration District No.: 3862
File No.: .....
Registered No.: 120

2. FULL NAME: Ida May Green - Col

(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: Female
4. COLOR OR RACE: Black
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): Nov 20 - 28

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| | 10 | 0 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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): Pemiscot Co

PARENTS
10. NAME OF FATHER: Willie Green
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): New Port Ark
12. MAIDEN NAME OF MOTHER: Melvina Brown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

14. INFORMANT: Willie Green
(Address) .....

15. FILED: Sept 21 1929 Ada Martin
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sep 20 1929

17. I HEREBY CERTIFY, THAT I attended deceased from ..... to ....., 19..., that I last saw ..... alive on ....., 19..., and that death occurred, on the date stated above, at 9-8-7 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Unknown
No attending
Physician
CONTRIBUTORY (SECONDARY) 200 A (duration) ..... yrs. ..... mos. ..... ds.
205 B

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? .....
Sept 21 1929 (Signed) Fred L. Agloe M.D
Health Officer (Title) Cauthersville 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: Netherland Mo
DATE OF BURIAL: Sep 21 1929

20. UNDERTAKER: Friends
ADDRESS: Cauthersville 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD