

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

2448

95

1. PLACE OF DEATH

County St. Francois
Township "
City Flat River (No. 416)

Registration District No. 774
Primary Registration District No. 601-80

File No. 95
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Mary Louise 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 3 1/2 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22-1842

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min.
88 11 27

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

9. BIRTHPLACE (CITY OR TOWN) Bonneterre
(STATE OR COUNTRY) MO

10. NAME OF FATHER Francis Aubuchon

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

12. MAIDEN NAME OF MOTHER Don't Know

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

14. INFORMANT Chas Bloomer
(Address) Flat River MO

15. FILED _____, 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 18, 1930, that I last saw her alive on Jan 17, 1930, and that death occurred, on the date stated above, at U.S.A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED? MO
IF NOT AT PLACE OF DEATH _____

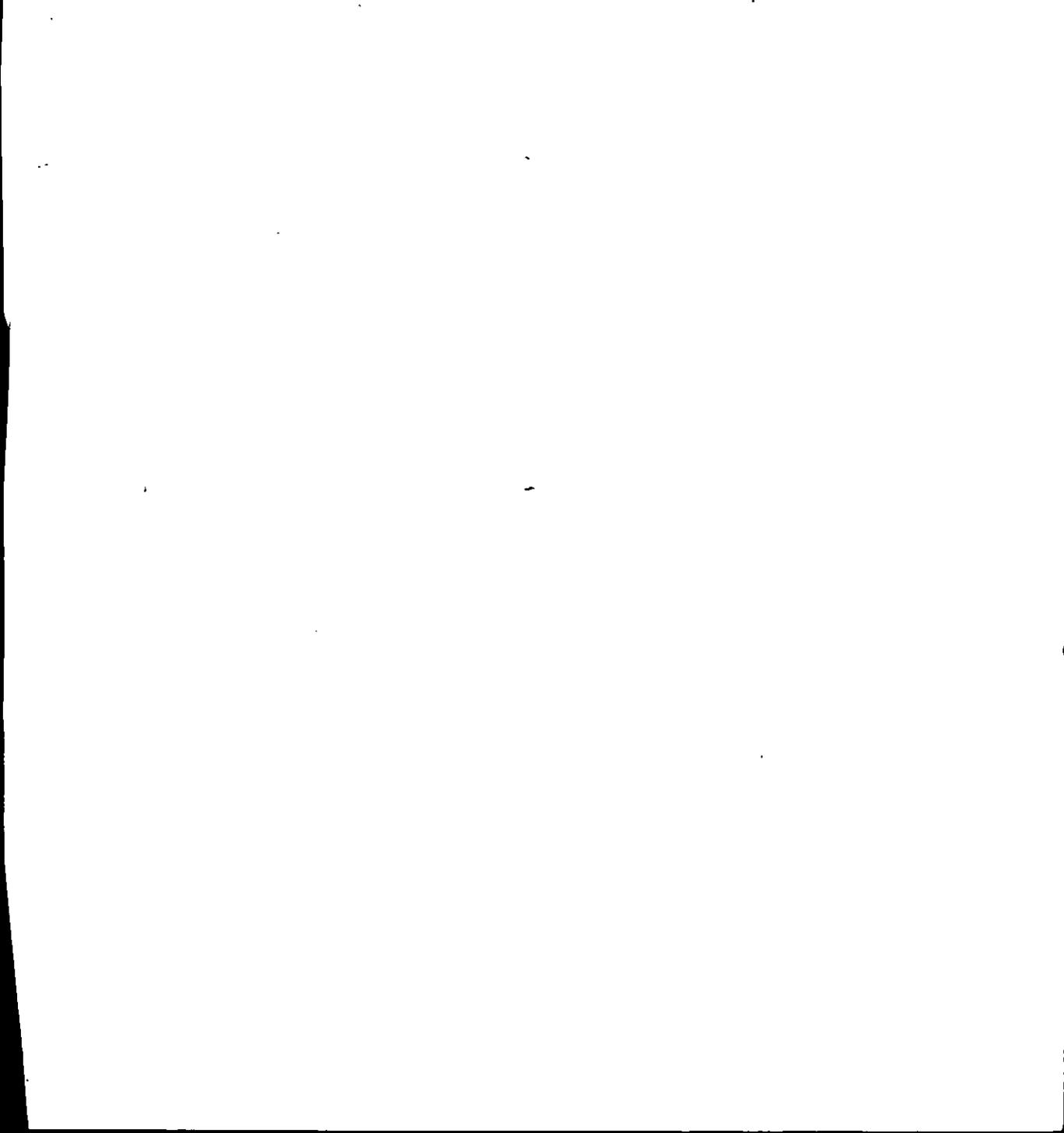
19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) E. Kohrbech, M. D.
Jan 19, 1930 (Address) Flat River 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 Bonneterre, MO DATE OF BURIAL Jan 20 1930

20. UNDERTAKER Tom G. ... Co ADDRESS Flat River MO



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Francois Registration District No. 974 File No. 95-
 Township Flat River Primary Registration District No. 2463 Registered No. _____
 City Flat River (No. _____) St. _____ Ward _____

2. FULL NAME

Mary Louise 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22 - 1842

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
87 11 26

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. FILED _____ 19. _____
W. J. Bryan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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 _____

THIS FORM MUST BE FILED WITHIN 24 HOURS OF DEATH. FAILURE TO FILE THIS FORM MAY RESULT IN A FINE OR PENALTY AS PRESCRIBED BY LAW.

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