APR 30 1930

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

Do not use this space.

9900

1. PLACE OF DEATH

County Randolph — Registration District No. 735 — File No.

Township — Primary Registration District No. 3034 — Registered No. 298

City Moberly (No. 406, Monroe St. Ward)

2. FULL NAME Greenberry White

(a) Residence. No. 406 Monroe 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	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 23rd 1844

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	85	5	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(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) Mo

PARENTS

10. NAME OF FATHER Harvey White

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Va

12. MAIDEN NAME OF MOTHER Vienia Holdman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

14. INFORMANT Mrs Martha White
(Address) Moberly, Mo

15. FILED 3/18, 1930 Dr Thos. S. Fleming REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 15th 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24 — 1929 to Mch. 15 — 1930 that I last saw him alive on Mch. 15 — 1930, and that death occurred, on the date stated above, at 11:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy — 83.4
137
133.8

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Arterial Hypertension & Prostatic Hypertrophy with retention.

(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? Clinical & Lab.

(Signed) L. E. Huber, M. D.

3-18th, 1930 (Address) Moberly, 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	DATE OF BURIAL
Moberly Mo	3-18th 1930
20. UNDERTAKER	ADDRESS
Mahan Ind Son	Moberly Mo

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

County: Randolph

Township:

City: Moberly (No. 406 Monroe St. Ward)

Registration District No. 735

Primary Registration District No. 3034

File No.

Registered No. 298

2. FULL NAME Greenbury White

(a) Residence. No. 406 Monroe 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	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23rd 1844

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	85	5	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Please note the name on this certificate is spelled "Greenbury White". The original sent in April 9th had name spelled "Greenberry". Please make this correction on your records.

Thos. S. Fleming
(Local Registrar)

(STATE OR COUNTRY)

INFORMANT

(Address)

15. FILED ....., 19..... Dr. Thos. S. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 15 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 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 19

20. UNDERTAKER | ADDRESS

5-9900