

NOV 26 1930

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

Do not use this space.

33568

1. PLACE OF DEATH

County Mississippi Registration District No. 566 File No. _____
Township Lyonsville Primary Registration District No. 3030 Registered No. 83
City Oshtemo (No. _____) St. _____ Ward _____

2. FULL NAME

Jennie 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 <u>Female</u>	4. COLOR OR RACE <u>Black</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Chester Green</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 5 1915</u>		
7. AGE YEARS <u>15</u>	MONTHS <u>10</u>	DAYS <u>1</u> If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Housewife</u> (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 <u>Graut Arnold</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Arkansas</u>
	12. MAIDEN NAME OF MOTHER <u>Audist Arnold</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Arkansas</u>	

14. INFORMANT Chester Green
(Address) Charleston Mo.

15. FILED Oct 6 1930 J. S. Vermin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 4 1930 7 A.M.
17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1930 to Oct 4, 1930
that I last saw him alive on Oct 2, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute indigestion
11 8/10
(duration) _____ yrs. _____ mos. 2 ds.
CONTRIBUTORY (SECONDARY) Unknown
(duration) _____ yrs. _____ mos. _____ ds.
18. WHERE WAS DISEASE CONTRACTED 1120
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) A. P. Marshall, M. D.
, 19 _____ (Address) Charleston 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 <u>Oak Grove Cemetery</u>	DATE OF BURIAL <u>Oct 6 1930</u>
20. UNDERTAKER <u>Lair and Co. Holly</u>	ADDRESS <u>Charleston Mo.</u>

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.

