

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.

DEC 22 1930

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

Do not use this space

35878 Dr. Lynn

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 20.0

City Springfield, Mo.

St. James Hospital

File No. _____

Registered No. 875

St. _____ Ward) _____

2. FULL NAME

Mr. Matilda E. Green

(a) Residence. No. Cobal, Mo. St. _____ Ward. _____

(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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-5-2 (P)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 78 Unknown

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

9. BIRTHPLACE (CITY OR TOWN) Richland Missouri (STATE OR COUNTRY)

10. NAME OF FATHER Seth Manes

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

12. MAIDEN NAME OF MOTHER Williams

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

14. INFORMANT (Address) Robert E. Green, Son, Cobal, Missouri

15. FILED 11-20-30 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 19 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 19, 1930, that I last saw her alive on Nov 19, 30 and that death occurred, on the date stated above, at 12:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Atherosclerosis

301 (duration) 6 yrs. — mos. — ds. CONTRIBUTORY (SECONDARY) Cerebral hemorrhage (duration) 2 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED 17401 IF NOT AT PLACE OF DEATH

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

WHAT TEST CONFIRMED DIAGNOSIS (Signed) Robert Lynn M. D. Nov 30 (Address) Springfield 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 Richland Mo DATE OF BURIAL 11-22 1930

UNDERTAKER Wm. Schreyer ADDRESS 534 St. Louis General Home

