

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

Do not use this space.

15839

1. PLACE OF DEATH
39 County Dreene Registration District No. 318
3 Township _____ Primary Registration District No. 200
5 City Springfield Baptist Hospital St. _____ Ward) _____
2. FULL NAME Willis Greek
(a) Residence, No. Sebanon mo. 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE <u>Mrs. Mary Greek</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 18 1879</u>		
7. AGE YEARS <u>53</u>	MONTHS <u>3</u>	DAYS <u>16</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		10. Date deceased last worked at this occupation (month and year)
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Laclede Co. Missouri</u>		
13. NAME <u>Adam Greek</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Saarny Germany</u>		
15. MAIDEN NAME <u>Elizabeth Hufft</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>		
17. INFORMANT <u>Ray Greek Sebanon</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Sebanon Mo</u> DATE <u>5-14-1932</u>		
19. UNDERTAKER <u>Alma Johnson</u>		
20. FILED <u>5/14 1932</u> <u>For Sharp</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 11 1932 to May 4 1932

22. I HEREBY CERTIFY, That I attended deceased from Apr 11 1932 to May 4 1932
I last saw him alive on May 4 1932 Death is said to have occurred on the date stated above, at 8:10 P m.
The principal cause of death and related causes of importance were as follows:
Meningitis (Streptococcus) Date of onset
Fiel. Skull
188
Other contributory causes of importance:
1

8 Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Hollis Smith M. D.
(Address) Springfield Mo

APR 22 1932

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Green
Township
City Springfield

Registration District No. 318
Primary Registration District No. 2001

File No.
Registered No. 339
St. Ward)

2. FULL NAME

Willis Greek

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19...

19. UNDERTAKER (ADDRESS)

20. FILED 7-6-1932 Ralph W. Langston Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 4, 1932

22. I HEREBY CERTIFY, That I attended deceased from

to 19...

I last saw him alive on 19... Death is said

to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

meningitis
Streptococcus
fractured skull

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? accident Date of injury 5-1-32

Where did injury occur? West Lebanon Mo
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

at home

Manner of injury knocked on head by mule

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) _____, M. D.

(Address) _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-15839