

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

Do not use this space.

45653

JAN 22 1937

1. PLACE OF DEATH

County Madaway  
Township  
City Maryville (No. St. Francis Hospital)

Registration District No. 628  
Primary Registration District No. 3081

File No. ....  
Registered No. 180  
St. .... Ward

2. FULL NAME

(a) Residence No. Joseph W. Greenway  
(Usual place of abode) Bedford Ave 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

MEDICAL CERTIFICATE OF DEATH

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

male - white widowed

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

Anna

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 14 - 1869

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

67 8 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Vidalia, Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER W M Greenway

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT G C Greenway  
(Address) Cedar Rapids Ia

15. FILED 12-13-36 Mamie E. Clardy  
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 13 1936

17. I HEREBY CERTIFY That I attended deceased from 12-9-36 to 12-13-36 that I last saw h. alive on 12-13-36, and that death occurred, on the date stated above, at 12:25 A m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Menigitis - traumatic

CONTRIBUTORY Fr. skull - Fr wrist  
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH. near Bedford Iowa

DID AN OPERATION PRECEDE DEATH? No DATE OF

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examined

(Signed) Francis Powell, 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 Gus Cemetery DATE OF BURIAL Dec 13 36

20. UNDERTAKER F L Wetmore ADDRESS Bedford Ia

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH**

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**1. PLACE OF DEATH**

County Madaway  
Township  
City Marquette (No. \_\_\_\_\_)

Registration District No. 625-  
Primary Registration District No. 3031

File No. \_\_\_\_\_  
Registered No. 159  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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**

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

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.
	<u>67</u>	<u>8</u>	<u>29</u>	

OCCUPATION  
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)

FATHER  
13. NAME

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

MOTHER  
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 72-13 1936 Mamie B. Clouds Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 13 1936

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ 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 traumatica Date of onset \_\_\_\_\_

Other contributory causes of importance: Fracture skull & wrist

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 Accidental Date of injury Dec 7, 1936

Where did injury occur? Rural 9 mi. S. of \_\_\_\_\_ (Specify city or town, county, and State)

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

Public Highway

Manner of injury auto collision

Nature of injury fracture skull & rt wrist

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

If so, specify \_\_\_\_\_

(Signed) Jack Rowlett, M. D.

(Address) \_\_\_\_\_

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