

REC'D MAY 18 1938

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

Do not use this space.

1. PLACE OF DEATH  
 County Cape Girardeau Registration District No. 124  
 Township Payson Primary Registration District No. 4070  
 City Jackson (No. 650 St. 650 Ward)

2. FULL NAME George J. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. 14261  
 Registered No. 18

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 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 Fannie Green

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 24 - 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
85 6 1

8. OCCUPATION OF DECEASED retired  
 (a) Trade, profession, or particular kind of work Laborer  
 (b) General nature of industry, business, or establishment in which employed (or employer) Retired 20 yrs  
 (c) Name of employer \_\_\_\_\_

16. DATE OF DEATH (MONTH, DAY AND YEAR) 25 of April 1938

17. I HEREBY CERTIFY That I attended deceased from 15 April 1938 to April 25 1938 that I last saw him alive on April 25 1938, and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hypostatic Pneumonia  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis - Nephritis  
10 years (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) Jackson Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Geo Green

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

12. MAIDEN NAME OF MOTHER Elizabeth Weston

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

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? None  
 (Signed) W. J. Johnson M. D.  
 1938 (Address) Cape Girardeau, Mo.

14. INFORMANT Mr. Geo Beath  
 (Address) Jackson Mo.

15. FILED 4-26-38 D. G. Gilbert REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL City Cemetery Jackson DATE OF BURIAL Apr 28 1938

20. UNDERTAKER 12 Crocraff - Miller ADDRESS Jackson Mo.

BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.  
 AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE  
 CAUSE OF DEATH AS ACCURATELY AS POSSIBLE.

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FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

142617  
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. ....  
(c) City Cape Girardeau (d) Street No. .... St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George J Green

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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, ....hra. or ....min.  
55 6 1

OCCUPATION

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

9. Industry or business in which work was done, as 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)

INFORMANT (ADDRESS)

BURIAL, CREMATION, OR REMOVAL

PLACE DATE, 19...

FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19.....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 25, 1938

22. I HEREBY CERTIFY, That I attended deceased from

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:

Hypostatic Pneumonia  
Bunchal - 1019

Date of onset

Other contributory causes of importance:

Arterio Sclerosis

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? ..... 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) Neil Johnston M.D.

(Address) Cape Girardeau MO

SUPPLEMENT

Every item of information should be carefully checked for accuracy so that it may be correct.

