

REC'D FEB 6 1938

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

2206

Do not use this space.

PLACE OF DEATH

(a) County Franklin Registration District No. 293
(b) Township _____ Primary Registration District No. 3016 Registered No. 2
(c) City Washington (d) Street No. St. Francis Hospital 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 2 yrs. 1 mos. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1050 ALEX GREEN
706 Missouri Ave. Washington, Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 6, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 8 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Own Farm
10. Date deceased last worked at this occupation (month and year) Dec 1936 11. Total time (years) spent in this occupation life

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

FATHER 13. NAME George Green

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

MOTHER 15. MAIDEN NAME Hannah Berry

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

17. INFORMANT (ADDRESS) Fred E. Parks Washington, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington, Mo DATE Jan 4 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Nichols & Witt, Inc. Washington, Missouri

20. FILED Jan 3 - 1938 Local Registrar H. A. May

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1st, 1939

22. I HEREBY CERTIFY That I attended deceased from Sept 3 - 1938 to Jan 1st, 1939

I last saw him alive on Jan 1, 1939. Death is said to have occurred on the date stated above, at 2:30 p. m.

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

Pneumonia Relapsa Date of onset Dec 24 38

Other contributory causes of importance:

Arterio-sclerosis Heart

Name of operation Prostatectomy Date Dec 9, 1938

What test confirmed diagnosis Biopsy 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? No
If so, specify _____

(Signed) R. R. Culler, M. D.
270 (Address) Washington, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Amount of information furnished is very important. PHYSICIANS should state EXACTLY. Amount of information furnished is very important.

1072

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

Lester H. Vitt

, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Lester H. Vitt

Licensed Embalmer No. _____

3254

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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2206
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 293
(b) Township Washington Primary Registration District No. 2016 Registered No. _____
(c) City _____ (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 Alex 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 Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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.
78 8 25

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)

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-1-1939

22. I HEREBY CERTIFY, That I attended deceased from 19__ 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:

Bronchial Pneumonia Date of onset _____
Bilateral 1937

Other contributory causes of importance:
Arterio Sclerosis heart
Hypertrophic simple of heart
Prostate

Name of operation Prostatectomy Date of _____ 19__

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? No 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) R. R. Cutler, M. D.

(Address) Washington Mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

S-2206