

MISSOURI JUN 24 1939

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

20036
Do not use this space.

1. PLACE OF DEATH

(a) County German Registration District No. 850
(b) Township Walker Primary Registration District No. 4093 Registered No. 8
(c) City Walker (d) Street No. Walker, Mo 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 Lola Amanda Louise Green

(a) Residence, No. Walker, Mo. 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 <u>F</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Isaac Green</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 6, 1868</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>6</u>
	DAYS <u>0</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housekeeper</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>at home</u>	
	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) <u>Forth Worth Texas</u>		
FATHER	13. NAME <u>Not known</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>	
MOTHER	15. MAIDEN NAME <u>Not known</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known</u>	
17. INFORMANT (ADDRESS) <u>Mrs Geo Still Walker Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>Walborn Cemot</u> DATE <u>May 7, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Ferny Walker Walker Mo</u>		
20. FILED <u>577</u> <u>1939</u> <u>W C B Davis</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1935, to May 6, 1939, 1939. I last saw him alive on May 6, 1939. Death is said to have occurred on the date stated above, at 2:01 m. The principal cause of death and related causes of importance were as follows:
Pulmonary Edema Date of onset

Other contributory causes of importance:
Left Ventricular Regurgitation

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? no

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) C. B. Davis, M. D.
Walker Mo (Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X-16005

RECEIVED

District Health Officer No. 7,
District File Number 7-29-968
Date Filed 6-12-39

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, or by _____

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

Signed Maize E. Ferry

Licensed Embalmer No. 1432

P. O. Address Nevada Mo

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.

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

20036

Do not use this space.

1. PLACE OF DEATH
 (a) County Vernon Registration District No. 980
 (b) Township _____ Primary Registration District No. 4533 Registered No. 8
 (c) City Walker (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 Amanda Louise 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M
 (write the word)
- 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>70</u> | <u>6</u> | <u>0</u> | |
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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-6 1939
22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
- I last saw h. alive _____, 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:
proboscary Edema
with renal failure
possibly with
steroids
- Other contributory causes of importance: 92 N
- 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) A. P. Davis, M. D.
 (Address) Walker, Mo.

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY more

Local Registrar

