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.

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

23444
Do not use this space.

1. PLACE OF DEATH DEC 1 2 1939
(a) County Stoddard 3 Registration District No. 834
(b) Township Pike 1 Primary Registration District No. 6097 Registered No. 27
or
(c) City Bell City R.F.D. (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 650 Glenn 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
m	w	married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 6, 1916

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	22	6	9	

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.
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) Bollinger Co. Mo.

FATHER
13. NAME Marion Green
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape County Mo.

MOTHER
15. MAIDEN NAME Ida Pixley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bollinger Co. Mo.

17. INFORMANT (ADDRESS) Marion Green Bell City Mo. R.F.D.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Gravel Hill DATE June 6, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chiles Und. Co. Bloomfield Mo.

20. FILED June 28, 1939 D S McGee
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from Unattended 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 3 30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Struck by lightning while driving tractor in field	

Other contributory causes of importance:

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? accident Date of injury June 5, 1939
Where did injury occur? Stoddard Co. Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Struck by lightning
Nature of injury Killed

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [illegible], M. D.
758 (Address) Bloomfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2
District File Number 739-42
Date Rec'd 2-11

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 Howard A. Cooper, Registered Apprentice No. ..... working under my personal supervision.

Signed Howard A. Cooper

Licensed Embalmer No. 3996

P. O. Address Bloomfield, Mo.

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

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