

1939 JUL 13 1939

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

23511
Do not use this space.

1. PLACE OF DEATH

(a) County Washington 2 Registration District No. 887
(b) Township Bretton 1 Primary Registration District No. 6179 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

Unnamed, Green
(a) Residence, No. Mural Point, 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 M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-15-1939
7. AGE YEARS MONTHS DAYS If LESS than 1 day, 5 hrs. or 3 min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
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) This Co, Mo - 0

FATHER 13. NAME Gene Green 0

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Del Run 0

MOTHER 15. MAIDEN NAME Winona Ratty

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson Co, Mo.

17. INFORMANT (ADDRESS) Gene Green, Mural Point, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mural Point DATE April 16, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sparks, Potosi, Mo.

20. FILED May 15, 1939 G. F. Cresswell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-15-1939

22. I HEREBY CERTIFY, That I attended deceased from 4-15-1939 to 4-15-1939

I last saw him alive on 4-15-1939 Death is said to have occurred on the date stated above, at 3 P. m.

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

premature 7 mo Date of onset _____

Other contributory causes of importance: Toxic complications of malaria

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 _____

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) Joseph L. Thurman, M. D.

(Address) Potosi, Mo.

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.

MARGIN RESERVED FOR RECORDING

50M-9-19-38 I X10605

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.....

Licensed Embalmer No.....

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.