

REC'D AUG 11 1939

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

26378  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Newton Registration District No. 609  
 (b) Township Waco Primary Registration District No. 8508  
 (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 Anna Greeman  
 (a) Residence, No. Rt 2 Granby 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED  
 HUSBAND OF E. J. Greeman  
 (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 22, 1881

7. AGE YEARS 58 MONTHS 7 DAYS 7 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 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) McDonald County Missouri

FATHER  
 13. NAME John Calvin Biggs  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

MOTHER  
 15. MAIDEN NAME Laurinda Burrow  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT (ADDRESS) E. J. Greeman Granby Mo R 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Granby Mo DATE July 28, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wheeler & Son Wheeler Mo

20. FILED 7-27 1939 Orval A. Sakum Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 I last saw him/her alive on July 26, 1939. Death is said to have occurred on the date stated above, at 6:30 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Cause unknown.  
Probable Pulmonary Tuberculosis.  
Had not consulted a Physician for 8 months.  
 Other contributory causes of importance: 23

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) Orval A. Sakum M.D. Address: Granby Mo

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.

**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, .....

*Wm. Marcus Poque*

....., or by .....

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

Signed

*Wm Marcus Poque*

Licensed Embalmer No. *3487*

P. O. Address *Wheaton Md*

**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

26378  
Do not use this space.

1. PLACE OF DEATH

(a) County Newton Registration District No. 609  
 (b) Township Hessko Primary Registration District No. 5808 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. (?) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Anna Freeman

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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) Dec. 22. 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
57 58 7 47

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as a 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 7-27 1939 Anna R. Schmidt  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-26 1939

22. I HEREBY CERTIFY, That I attended deceased from

1939, to 1939

I last saw h. alive on 7-26, 1939 Death is said

to have occurred on the date stated above, at 7-26 m.

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

Date of onset

Other contributory causes of importance:

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) Carley Thompson

(Address) Hessko

SUPPLEMENTARY

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

5-26378

1939