

REC'D SEP 19 1939

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

Do not use this space.

29947

1. PLACE OF DEATH
County Sheep Registration District No. 678
Township St James Primary Registration District No. 1904
City St James Mo St James Hospital St. _____ Ward) _____
460
2. FULL NAME John Raymond Green
(a) Residence, No. _____ St. _____ Ward. _____
(Usual place of abode) _____ (If nonresident, give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 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) June 5, 1920
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 2 28
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farming
9. Industry or business in which work was done, as silk mill, 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) Marie Co Mo
13. NAME Edland Miller
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marie Co Mo
15. MAIDEN NAME Beal Durison
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keokuk Mo
17. INFORMANT (ADDRESS) Edland Miller
Green Road 2
18. BURIAL, CREMATION, OR REMOVAL PLACE Keokuk DATE Sept 5 1939
19. UNDERTAKER (ADDRESS) Fullerton
Keokuk Mo
20. FILED 9-5- 1939 Elcie B. Hawk
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-3 1939
22. I HEREBY CERTIFY, That I attended deceased from 8-31- 1939, to 9-3- 1939
I last saw him alive on 9-3- 1939 Death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:
Pericarditis Aneuria Date of onset _____
Other contributory causes of importance: MI
Name of operation no lab Date of _____
What test confirmed diagnosis? lab 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) E. d. Scott M. D.
(Address) St James Hospital
St James Mo

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.

RECEIVED

District Health Officer No. 5,

District File Number 939187

Date Filed 9/1/39