

1150 OCT 12 1939

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

31937
Do not use this space.

1. PLACE OF DEATH
 (a) County Cochran Registration District No. 85
 (b) Township _____ Primary Registration District No. 1001 Registered No. 986
 (c) City St. Joseph Mo (d) Street No. Missouri Methodist Hosp. 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 Baby Greenslitt
 (a) Residence, No. 711 Jefferson St. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Baby
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Baby
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 22 - 1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, 3 hrs. or min.
3 days 1939 Sept 22
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Baby
 9. Industry or business in which work was done, as saw mill, bank, etc. Baby
 10. Date deceased last worked at this occupation (month and year) Baby 11. Total time (years) spent in this occupation ✓
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri Methodist Hosp. St. Joseph Mo
 FATHER 13. NAME Unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 0
 MOTHER 15. MAIDEN NAME Lucille Greenshaw
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Parnell Mo 0
 17. INFORMANT (ADDRESS) Lucille Greenslitt 711 Jefferson St. St Joe
 18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE Sept. 25 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. E.R. Sidenfaden 602 So 10th St.
 20. FILED Sept 25 1939 A J Mettelbuch Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25 1939
 22. I HEREBY CERTIFY, That I attended deceased from 9/25 1939 to 9/25 39
 I last saw him alive on 9/25/39 19... Death is said to have occurred on the date stated above, at 5:00 a.m.
 The principal cause of death and related causes of importance were as follows:
Pneumonia broncho bilateral Date of onset _____
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? autopsy Was there an autopsy? yes
 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) H. C. Petersen M. D.
 (Address) St. Joseph Mo

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

1150 7
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.

107A

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. *Not Embalmed*

Signed *Theron D. Smith*

Licensed Embalmer No. *3928*

P. O. Address *St. Joseph 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.

Married name of mother is Greenslit.

Seperated from husband but *not divorced*

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

31937 X
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township St Joseph Primary Registration District No. 1001 Registered No. 986
 (c) City St Joseph (d) Street No. _____
 (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 Baby Greenblatt

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Baby

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25 1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the day stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min. 3

Pneumonia 2 Broncho
lobar

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 _____

no complications
 Date of onset 10/1/39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Other contributory causes of importance: _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 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 9-25 1939 A. H. Nestoruck
 Local Registrar.

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) Hot. Petersen M. D.
 (Address) St Joseph

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 LAW.

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