

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10343
Registrar's No. 79

Registration District No. 89

Primary Registration District No. 5131

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Neelyville, Mo.
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) 650

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler
(c) City or town Neelyville, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 0 Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME Charles Green

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alice 6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased Aug. 12, 1896
(Month) (Day) (Year)

8. AGE: Years 43 Months 8 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Sharp Co. Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Joe Green
13. Birthplace Sharp Co. Ark.
(City, town, or county) (State or foreign country)
14. Maiden name Fannie Rattler
15. Birthplace Sharp Co. Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Alice Green

(b) Address Neelyville, Mo.

17. (a) Burial (b) Date thereof Mar 31, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Neelyville Cem.

18. (a) Signature of funeral director Greer-Croy Service

(b) Address Poplar Bluff, Mo.

19. (a) 4/2/40 (b) Oldenburg
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1940 hour 1 minute P M.

21. I hereby certify that I attended the deceased from Oct 21, 1918 to Mar 29, 1940
that I last saw him alive on Jan 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Duration 2 yrs

Due to _____
Due to JA

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. Eastman (M. D. or other) _____
Address Poplar Bluff, Mo. Date signed 4/2/40

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..... *Good W Green*

Licensed Embalmer No. *2964*

P. O. Address..... *Poplar Bluff*

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.