

S. No. 2
-11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17880

State File No. _____

JUN 10 1940 85

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 521

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1614 BEATHIE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 2 YEARS 22 DAYS years, months or days)

3. (a) PRINT FULL NAME MARY FRANCES GREER

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race White

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased APRIL 14th 1938
(Month) (Day) (Year)

8. AGE: Years 2 Months 0 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace St Joseph Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER

12. Name Russell Greer

13. Birthplace Buchanan city, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Eula Martin

15. Birthplace St Joseph, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant MR. RUSSELL GREER

(b) Address 1614 BEATHIE St. Joseph

17. (a) BURIAL (b) Date thereof MAY 8th 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St Joseph

19. (a) MAY 7 1940 (b) AD Nestle bush
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 1614 BEATHIE
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 6th
year 1940 hour 9 minute 00 A. M.

21. I hereby certify that I attended the deceased from May 3, 1940
_____ 19____ to May 6, 1940
that I last saw h. E.R. alive on May 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Septicemia & 1150

Pneumonia -

Due to Streptococcus _____ weeks

inf. - probably originating in tonsils

Due to _____

Other condition Osteomyelitis - acute relaps
(Includes pregnancy within 3 months of death)

Plausis - fibrinous PHYSICIAN _____

Major cause of death abscess of myocardium
or operation _____

infarcts (septal) of heart Underline _____
the cause to which death should be charged statistically.

fibrinous pericarditis

infectious abscesses heart

Septic infarcts lung or

22. If death was due to external cause, name as follows:

(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? _____

85 (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature J. T. Bloomer (M. D. or other) _____

Address 1218 N. 3rd St. Joseph, Mo Date signed 5/6/40

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.....

C. G. Swan

Licensed Embalmer No. *4082*

P. O. Address *St. Joseph*

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.