

Registration District No. **449**

Primary Registration District No. **4267**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **LACLEDE**  
(b) City or town **LEBANON**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **105<sup>th</sup> IN AVE BEHIND POLK AVE 2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **SINCE APR. 1939** years, months or days)

8. (a) PRINT FULL NAME **JOHN WILLIAM GREEN (U.S.)**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **MELINA CARTER** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **JUNE 16 1862**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **1** Days **26**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **CHRISTIAN CO. KY**  
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business **9**

12. Name **9**

18. Birthplace **9**  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **OLDAGE ASST. OFFICER**

(b) Address **LEBANON MO**

17. (a) **BURIAL** (b) Date thereof **8-12-1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **LEBANON**

18. (a) Signature of funeral director **PALMER'S**

(b) Address **LEBANON**

19. (a) \_\_\_\_\_ (b) **404**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **LACLEDE**  
(c) City or town **LEBANON**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **105 Polk Ave**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **12**  
year **1940** hour **12** (minute **40 P. M.**)

21. I hereby certify that I attended the deceased from **Dead when picked up**, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **HEART ATTACK** Duration \_\_\_\_\_

Due to **OVER EXERTION**

Due to \_\_\_\_\_

Other conditions **9**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **Corner**

23. Signature **J. D. Stauffer** (M.D. or other) **Coroner**

Address **LEBANON MO** Date signed **8-12-40**

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. 7,  
District File Number 9-40-1348  
Date Filed 9-16-40

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

Registration District No. **449**

Primary Registration District No. **4267**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Laclede**  
(b) City or town **Levanon**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME **John William Green**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex **m**  
5. Color or race **w**  
6. (a) Single, widowed, married, divorced **m**  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years **78** Months **1** Days **26**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **10-15-40** (b) **Jam Condit**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **12**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

