

10-39
17-39
X21492

Registration District No. **470**

Primary Registration District No. **5433**

Registrar's No. **132**

NOV 20 1940

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 4 days
years, months or days

3. (a) PRINT FULL NAME Greene Exendine

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alta Exendine
6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased June 11th 1876
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 2
If less than one day hr. min.

9. Birthplace Brownfield Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business None

12. Name Welsly Exendine

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

14. Maiden name Tilda West

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

16. (a) Informant E. McMichael, Recrd Clerk

(b) Address Missouri State Sanatorium

17. (a) Burial (b) Date thereof Oct 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sanatorium Cemetery

18. (a) Signature of funeral director Robert J. ...
(b) Address Mt. Vernon, Mo.

19. (a) 10-16-40 (b) P.A. Ho L MFS
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County LaClede
(c) City or town Dry Knob, Mo.
(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 October day 16th
year 1940 hour 4:45 minute A.M.

21. I hereby certify that I attended the deceased from October 12th, 1940, to October 16th, 1940
that I last saw him alive on October 15th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Brain Abscess & Meningitis
Due to Pulmonary abscess 1 year
Duration 12 weeks

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

Major findings: _____
Of operations _____

Of autopsy Brain Abscess, Meningitis
Lung abscess
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? Yes
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature W. Stricker M.D.
Address Mt. Vernon Date signed 10-16-40

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

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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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38-706

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town St. Vermont, P.
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Greene Ependine
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 _____ year
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(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.

20. DATE OF DEATH: Month Oct day 16
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Brain abscess
at meningitis
pulmonary abscess

Due to _____
Due to unknown
N.M.D.

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

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

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 M. J. Lockes (M. D. or other) _____
Address St. Vermont, P. Date signed 10-18-40

SUPPLEMENTARY

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

