

S. No. 2  
-11-10  
v. 5-17  
I 2212

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35748**  
Registrar's No. \_\_\_\_\_

NOV 20 1940  
Registration District No. **503**

Primary Registration District No. **5669**

8

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

1. PLACE OF DEATH:  
(a) County **LINN CREEK TOWNSHIP**  
(b) City or town **PARSON CREEK TOWNSHIP**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **NONE**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **NONE** **20**  
In this community **50 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **LINN**  
(c) City or town **RURAL Meadville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Route No 1**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? **L** years.

3. (a) PRINT FULL NAME **LYDIA GREEN**

MEDICAL CERTIFICATION

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **140**

20. DATE OF DEATH: Month **Oct 5** day **5** year **1940** hour **10** minute **4** M.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WID.**

21. I hereby certify that I attended the deceased from **Sept** 19**40** **Oct 5** 19**40**

6. (b) Name of husband or wife **DAVID A GREEN** 6. (c) Age of husband or wife if alive **Dec** years

that I last saw her alive on **Sept 30** 19**40** and that death occurred on the date and hour stated above.

7. Birth date of deceased **MCH. 30 1857**  
(Month) (Day) (Year)

Immediate cause of death **Cerebral thrombosis**

8. AGE: Years **83** Months **6** Days **5** If less than one day hr. — min.

Due to **arterio sclerosis**

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

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

10. Usual occupation **HOUSEKEEPER**

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

11. Industry or business **FARMERS WIFE**

12. Name **HENRY M. GRAY**

13. Birthplace **MARION CO. ILL.**  
(City, town, or county) (State or foreign country)

14. Maiden name **BETTY E. COX**

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

PHYSICIAN  
Major findings: Of operations **HTN**  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs Alice Draby**  
(b) Address **Meadville Mo. R. 1**

17. (a) **Burial** (b) Date thereof **Oct 7 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation **MONROE CEMETERY**

(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**

18. (a) Signature of funeral director **Emley Funeral Home**  
(b) Address **Whiting Mo**

23. Signature **E. W. Wein** (M. D. or other) **1**  
Address **Meadville** Date signed **Oct 7 1940**

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 \_\_\_\_\_

NO Embalming, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Frank L. Smiley

Licensed Embalmer No. 470

P. O. Address Wheeling 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.