

FEB 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

44091

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Leadville, RURAL
(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

3. (a) PRINT FULL NAME

GREEN METHENY3. (b) If veteran, name war no -3. (c) Social Security No. no -4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W4. (b) Name of husband or wife Liza Ann French 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Apr 7 1861
(Month) (Day) (Year)

8. AGE:

Years 79 Months 5 Days 20 If less than one day _____ hr. _____ min.9. Birthplace Tenn
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name Metheny13. Birthplace Tenn.
(City, town, or county) (State or foreign country)14. Maiden name Liza Ann French15. Birthplace Tenn.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Jack Wood(b) Address Leadville, Ark.17. (a) Burial (b) Date thereof Oct 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mount Grove yard18. (a) Signature of funeral director T. D. Lawrence(b) Address Leadville, Ark.19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madison
(c) City or town Leadville, RURAL
(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 Oct day 23
year 1940 hour 7 minute _____ P.M.21. I hereby certify that I attended the deceased from Oct 19 1940 to Oct 20 1940
that I last saw him alive on Sept 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Cardiac failureDue to Cardio-renalDue to arteriosclerosisDue to degenerative

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 J. E. Rapch (M. D. or other) _____Address Leadville, Ark. Date signed 10/24

RECEIVED

District 08 h Officer

District File Number 141-

Date Filed 4/9/4

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 44091

Registration District No. 834

Primary Registration District No. 6092

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Stoddard
 (b) City or town Blue T.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 _____
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME Green Metheny
 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 w

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 Months Days If less than one day
79 5 20 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/20/41 (b) D.S. McKe
(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 Oct day 23
 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 _____

Duration _____
 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 E.G. Cope (M. D. or other) _____

Address Hornersville Date signed _____

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

SUPPLEMENTAL ENTRY

