No. 2
4-13-40
-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 14 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25291

Registration District No. 408 — Primary Registration District No. 3020 — Registrar's No. 114

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stone Memorial Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ~~[illegible]~~ 5 days (Specify whether years, months or days)
In this community 9 years

2. USUAL RESIDENCE OF DECEASED: 047
(a) State: Missouri (b) County: Jasper
(c) City or town: ~~Carthage~~ Rural, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No.: 5 miles west of Carthage
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Virginia Mae Greninger
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: F. 1
5. Color or race: W.
6. (a) Single, married, widowed, divorced: Single 0
6. (b) Name of husband or wife: Student
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: May (Month) 24 (Day) 1932 (Year)

8. AGE: Years	Months	Days	If less than one day
9	3	3	hr. min.

9. Birthplace: Jasper County (City, town, or county) Missouri 10 (State or foreign country)
10. Usual occupation: school child
11. Industry or business: school
FATHER
12. Name: Oliver Greninger
13. Birthplace: no data (City, town, or county) Missouri 0 (State or foreign country)
MOTHER
14. Maiden name: Leona Harp
15. Birthplace: Jasper County (City, town, or county) Missouri 0 (State or foreign country)
16. (a) Informant: Father Oliver Greninger
(b) Address: Carthage, Mo. R.R.#4
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Emanuel Cemetery
18. (a) Signature of funeral director: Helge Nelson
(b) Address: Webb City, Missouri
19. (a) July 29, 1941 (Date received local registrar) (b) E. J. McIntire, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 27 day 27 year 1941 hour 3:25 minute A M.
21. I hereby certify that I attended the deceased from Dec 24, 1940 to July 27, 1941 that I last saw her alive on July 27, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pernicious anemia	3 mo.
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Albert B. Wheeler D.O. (M.D. or other)
Address: Carthage, Mo. Date signed July 29, 41

(Licensed Embalmer's Statement on Reverse Side)

41-8-703

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 T. W. Hedge

Licensed Embalmer No. 2859

P. O. Address Webb City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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STANDARD CERTIFICATE OF DEATH

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Registration District No. 408 | Primary Registration District No. 3020 | Registrar's No. 114

1. PLACE OF DEATH:

(a) County: Jasper

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

(c) Name of hospital or institution: Stone Memorial Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 da (Specify whether years, months or days) In this community ~~[illegible]~~

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jasper

(c) City or town: Rural (If outside city or town limits, write "RURAL")

(d) Street No.: 5 mi W. of Carthage (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Virginia M. Greninger

3. (b) If veteran, name war: 0

3. (c) Social Security No. .....

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

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: 9 | Months | Days | 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) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

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

(b) Address .....

19. (a) Sept. 16, 1941 (Date received local registrar) (b) E. J. McIntire, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July Day: 7 Year: 1941 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 ..... Duration

Due to .....

Due to .....

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

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

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

S-25291