

No. 2  
-1-4-41  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34812

State File No. \_\_\_\_\_

Registration District No. 289

Primary Registration District No. 4173

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Malden, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community 4 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin

(c) City or town Malden 353  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Harriett E. Greathouse

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

4. Sex female 5. Color or race wh 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife R. H. Greathouse 6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased September 27, 1855  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30  
year 41 hour 3 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Sept 20, 1941, to Sept 30, 1941, that I last saw him alive on Sept 29, 1941, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>0</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation housewife

Immediate cause of death Myocarditis

Due to eye

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

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

Major findings: Of operations 93

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

MOTHER FATHER

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

12. Name Dr. S. C. Latham

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

14. Maiden name D. K.

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

16. (a) Informant S. L. Greathouse  
(b) Address Malden, Mo.

17. (a) burial (b) Date thereof 10-2-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Travel Hill St. Francis

18. (a) Signature of funeral director Winnigan Funeral Home  
(b) Address Malden, Mo.

19. (a) 10-14-41 (b) S. E. Mitchell  
(Date local registrar) (Registrar's signature)

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 Dr. S. C. Latham (D. or other) OB  
Address Malden Date signed Sept 30 1941

Duration Paul

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2,

District File Number 1141-1493

Date Filed 11-2-41

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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 *A. Balman*

Licensed Embalmer No. 2556-

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; fact should be so stated above.**