

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

FILED JUL 25 1942

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Shannon
 (b) City or town rural
 (c) Name of hospital or institution Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 25 yrs years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Shannon **101**
 (c) City or town rural (If outside city or town limits, write "RURAL") **0**
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME Jasper Green
 3. (b) If veteran. no name war
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 8
 year 1942 hour 12 minute 23 M.

4. Sex male 5. Color or race white
 6. (b) Name of husband or wife Ida 6. (c) Age of husband or wife if divorced married
 7. Birth date of deceased Aug. 9 1886
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 4 1941 to Jan 8 1942
 that I last saw him alive on Dec. 27 1941
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
75 4 29 hr. min.

Immediate cause of death Broncho-Pneumonia **1: mo**
 Due to nephritis
 Due to senility

9. Birthplace Breathitt Co. Ky. 1
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

10. Usual occupation Farming

MOTHER FATHER
 11. Industry or business _____
 12. Name Crook Green
 13. Birthplace Ky. 1
 (City, town, or county) (State or foreign country)
 14. Maiden name Donna Michael Sparks
 15. Birthplace Ky. 1
 (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Lawrence Murphy
 (b) Address Senona, Mo.

While at work? _____ (Specify type of place)
 Means of injury fall
 23. Signature Wm. H. Burton (M. D. or other) **mw**
 Address Senona, Mo. Date signed 1-8-42

17. (a) Burial (b) Date thereof 1-10-42
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Home Country

18. (a) Signature of funeral director None
 (b) Address _____
 19. (a) 1-9-42 (b) Frank Hyde M.D.
 (Date received local registrar) (Registrar's signature)

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

101
0
0

RECEIVED

District Health Officer No. 5,

District File Number 442318

Date Filed 7-24-42

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22421

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Rural, Bowland Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 25 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon
(c) City or town Rural, Bowland Twp
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 8
year 1942 hour 9 minute 23 M.
21. I hereby certify that I attended the deceased from Dec 4
9:45 to June 8, 1942
that I last saw him live on Dec 27, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Due to Chronic nephritis
Due to scirrhosity

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

Major findings: 1318
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 _____ (M. D. or other)
Address _____ Date signed _____

3. (a) PRINT FULL NAME Jasper Green
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 Jda 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Aug 9 (Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 15 (If less than one day, h. min.)

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

10. Usual occupation _____

11. Industry of business _____

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) 1-9-42 (b) Frank Hyde MD
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

SUPPLEMENTAL

S-22421