FILED AUG 1 1942

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

46

24444

Do not use this space.

1. PLACE OF DEATH
(a) County Howell. Registration District No. 385 Primary Registration District No. 4228 Registered No. 15
(b) Township or
(c) City Willow Springs (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Derrell Green.
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1942-2-18.

7. AGE: Years | Months | Days 13 | If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. ✓
9. Industry or business in which work was done, as saw mill, bank, etc. ✓
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Douglas Co. Mo.

FATHER
13. NAME Josh Green
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Douglas Co. Mo.

MOTHER
15. MAIDEN NAME Ethel Collins
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Douglas Co. Mo.

17. INFORMANT Mrs. J. L. Puckett. (ADDRESS) City

18. BURIAL, CREMATION, OR REMOVAL PLACE Holmesburn DATE 3-4-42

19. FUNERAL DIRECTOR (NAME) None (ADDRESS)

20. FILED 3-3-42 19 M. Ferguson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-3-1942

22. I HEREBY CERTIFY, That I attended deceased from 3-3-, 1942, to 3-3-, 1942
I last saw h. alive on 3-3-, 1942. Death is said to have occurred on the date stated above, at 12:00 noon m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Broncho-pneumonia	3-1-42

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) O. O. Gallehan, M. D.
(Address) Willow Springs Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

X16605

RECEIVED
District Health Officer No. 5,
District File Number 742446.
Date Filed 7. 28. 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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24444

Registration District No. 385 Primary Registration District No. 4228 Registrar's No. 157

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

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Willow Springs
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Derell 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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 18 (Day) 1924 (Year)
8. AGE: Years Months Days 13 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 3 year 1942 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.

	Duration
Immediate cause of death Bronchopneumonia	
Due to N.M.O.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 107	
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? (c) Means of injury
23. Signature O. O. Callihan (M. D. or other)
Address Date signed

SUPPLEMENTARY