

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

**3231**  
Do not use this space.

**FILED FEB 11 1943**

1. PLACE OF DEATH *Ray*  
 (a) County *Ray* Registration District No. *298*  
 (b) Township *South* or *Lawson* Primary Registration District No. *4488*  
 (c) City *Lawson* (d) Street No. *1* St. *0*  
 (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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *JAMES SHERMAN GREEN*  
 (a) Residence, No. *Lawson, Mo.* St.  (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) *1 Married*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Susan Green*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan - 8 - 1869*  
 7. AGE YEARS *74* MONTHS *15* DAYS *15* If LESS than 1 day, .....hrs. or .....min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired Farmer*  
 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

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 23* 19*43*  
 22. I HEREBY CERTIFY, That I attended deceased from *Jan 15* 19*43* to *Jan 23* 19*43*  
 I last saw him alive on *Jan 22* 19*43* Death is said to have occurred on the date stated above, at *2:15 A.M.*  
 The principal cause of death and related causes of importance were as follows:

*Chronic Myocarditis -  
Acute Fibrinous Pericarditis*

Date of onset

Other contributory causes of importance: *90%*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

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) *Clara E. Buehner*, M. D.  
 (Address) *Lawson, Mo.*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*  
 FATHER 13. NAME *James Green*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *9*  
 MOTHER 15. MAIDEN NAME *Mary Rufft*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *9*  
 17. INFORMANT (ADDRESS) *Elyse Green Lawson, Mo.*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Union Cemetery* DATE *Jan 25* 19*43*  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Marion - Prichard Lawson, Mo.*  
 20. FILED *1-25* 19*43* *W.A. Blue* Local Registrar.

*114*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

I X16805

RECEIVED

Health Officer No. 8,

Number

2-10-43

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 *Robert Ray*.....

Licensed Embalmer No. *4182*.....

P. O. Address *Excelsior Spgs., Mo.*.....

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.