DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

17-39
X26390

FILED JUN 30 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22573

Registration District No. 355 | Primary Registration District No. | Registrar's No. 5

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

1. PLACE OF DEATH:
(a) County Shannon Co.
(b) City or town Summersville 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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Shannon 101
(c) City or town Hartshorn Mo
(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 0

3. (a) PRINT FULL NAME Zetta Greene
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race 7
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or wife James H. Greene
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased (Month) (Day) (Year)

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

9. Birthplace (City, town, or county) 9 (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name Francis M Irland
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name Rachel Stark
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant ~~Ed German~~ Mr Ireland
(b) Address Hartshorn, Mo.
17. (a) ~~Burial~~ (Burial, cremation, or removal) (b) Date thereof 12 11 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Hartshorn
18. (a) Signature of funeral director Ed. German
(b) Address Hartshorn, Mo.
19. (a) May 4, 1943 (Date received local registrar) (b) Mrs Fred Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 10th year 1942 hour 2 a minute M.
21. I hereby certify that I attended the deceased from Mr Ward Medical Attention 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	
Due to Natural Causes	1
Due to An invalid for years.	
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 0
23. Signature Dr J M Reeds (M.D. or other)
Address Summersville Date signed

744

(Licensed Embalmer's Statement on Reverse Side)

JUL 29 194

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 wi the above constitutes grounds for revocation of license.)

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

No. 2B
M—5-43
> I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 355 Primary Registration District No. 6203 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Shannon Co.

(b) City or town Rural Shannonsville, Mo.
(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 Zetta Greene

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 12 (Day) (Year)

8. AGE: Years 65 Months Days If less than one day hr. min.

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

10. Usual occupation Invalid

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) May 4 1942 (Date received by local registrar) (b) Mrs Fred Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 18 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	
Due to old age	
Due to an invalid for yrs.	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

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S-22573