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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24952

FILED AUG 9 1943

Registration District No. 310 1228

Primary Registration District No. 2000

State File No. _____

Registrar's No. 591

1. PLACE OF DEATH
 (a) County GREENE
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Burge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Hospital - 21 Mo. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 39
 (a) State Missouri (b) County Greene
 (c) City or town Springfield (If outside city or town limits, write "RURAL")
 (d) Street No. Route 7 Box 368 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Tessy Jean Greene
 (b) If veteran, name war None (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 23rd
 year 43 hour 16 minute 20 A M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Inf.
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years
 7. Birth date of deceased 7 23 43
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 23, 1943 to July 23, 1943
 that I last saw him alive on July 23, 1943
 and that death occurred on the date and hour stated above.

8. AGE: Years 0 Months 0 Days 0 If less than one day hr. 21 min.

Immediate cause of death Splenic infarct
 Due to congenital malformation
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace Springfield Mo. (City, town, or county) (State or foreign country)
 10. Usual occupation Infant
 11. Industry or business _____

Major findings: 1576
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name Wm. Gousha Greene
 13. Birthplace Marion Springs Ark. (City, town, or county) (State or foreign country)
 14. Maiden name Lucie Lealus McNamee
 15. Birthplace Pocahontas Ark. (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 Mrs. W. G. Greene
 (b) Address R. 7, Box 368, Springfield, Mo.
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-43 (Month) (Day) (Year)
 (c) Place: burial or cremation Greenlawn
 18. (a) Signature of funeral director Ered C. Thomas
 (b) Address 1160 Boonville Ave., Springfield, Mo.
 19. (a) 7-23-43 (Date received local registrar) (b) W. G. Greene (Registrar's signature)

23. Signature Arthur R. Smith (Specify type of place) (M.D. or other)
 Address 400 1/2 E. Cecil Date signed 7-23-43

984

(Licensed Embalmer's Statement on Reverse Side)

Spl. inf. Mo

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.

Not embalmed
Signed..... *Fred C. Hein*.....

Licensed Embalmer No. *2899*.....

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.