

Registration District No. **157**

Primary Registration District No. **3028**

Registrar's No. **231**

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Carthage**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **McCune-Brooks Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 days**
(Specify whether years, months or days) **6 years**

3. (a) PRINT FULL NAME **Fred Morton Green**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Eula Green** 6. (c) Age of husband or wife if alive **53** years

7. Birth date of deceased **March 25 1890**
(Month) (Day) (Year)

8. AGE: Years **53** Months **8** Days **21** If less than one day hr. min.

9. Birthplace **Mountain Grove Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **None**

12. Name **Harry Green**

13. Birthplace **Mountain Grove Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Ira Loney**

15. Birthplace **Mountain Grove Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Fred Green**

(b) Address **Route 1, LaRussell, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec. 19, 1943**
(Month) (Day) (Year)

(c) Place: burial or cremation **Red Oak Cemetery**

18. (a) Signature of funeral director **Knell Mortuary**

(b) Address **Carthage, Missouri**

19. (a) **Dec. 18 '43** (Date received local registrar) (b) **E. Elizabeth Caplin** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 1, LaRussell**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **- - -**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **16th** day **December**
year **1943** hour **2:27** minute **A** M.

21. I hereby certify that I attended the deceased from **Aug 24 1943** to **Dec 16 1943**
that I last saw him alive on **Dec 15 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **neurotic abscess of left axilla**
Due to **Infected bite of tick** 5 mo

Other conditions **malnutrition; toxemia**
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
5 mo
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) **Tick Bite, Summer of 1943**
(b) Date of occurrence **Summer of 1943**
(c) Where did injury occur? (City or town) (County) (State)
on farm
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) Means of injury

23. Signature **R. B. Clinton** (M. D. or other) **MD**
Address **Carthage, Mo** Date signed **12/17/43**

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

MOTHER, FATHER

43-12-1139

JAN 24 1944

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..... *Emma R. Kneel*

Licensed Embalmer No. *391*

P. O. Address..... *Carthage*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County *Gasper*
(b) City or town *Carthage*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution *One Cure Brooks Hosp.*
(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)

3. (a) PRINT FULL NAME

Fred M. 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 *w*

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

7. Birth date of deceased *mar. 25*
(Month) (Day) (Year)

8. AGE: Years *53* Months *8* Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* Day *16*
year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw him alive on _____, 19____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Septic abscess of left axilla
Due to *Insect bite of tick*
Due to *malnutrition*
overnight
Other conditions *all blood and tissue tests (lab. etc) negative*
(Include pregnancy within 3 months of death)

Major findings: Of operations *simple an infected neglected abscess which might be due to any cause*

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) *allergic bite of tick*
(b) Date of occurrence *unknown - about 6 mos prior to death*
(c) Where did injury occur? *Don't know* (City or town) (County) (State)
(d) Did injury occur in or on home, on farm, in industrial place, in public place? *probably on farm*
(Specify type of place)
While at work? *Don't know* (e) Means of injury *Don't know*
23. Signature *Floyd B. Clifton* (M. D. or other) *MD*
Address *Carthage Mo* Date signed *1/18/44*

SUPPLEMENTAL

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

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

THE STATE BOARD OF HEALTH OF MISSOURI

January 11, 1944

75254-2

L. B. Clinton, M. D.
304 Grant
Carthage, Missouri

Dear Doctor Clinton:

On checking over the death certificates I noticed that in the case of Fred Norton Green who died December 16, 1943 you gave as cause of death "Necrotic abscess of left axilla" due to "Infected bite of tick".

Dr. John W. Williams, Jr., of the Missouri State Board of Health has seen many cases of tularemia resulting from tick bites. I am interested to know whether you ran an agglutination for tularemia in this case.

Respectfully,

Robert M. Ferguson, M. D.
Jasper County Health Officer

c.c. State Board of Health
RMF-HS