

No. 2  
1-2-43  
5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUL 13 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21920

Registration District No. 383

Primary Registration District No. 5655

Registrar's No. 94

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mount Vernon Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 61 days  
(Specify whether years, months or days)

In this community 61 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Gideon, Mo 7-2  
(If outside city or town limits, write "RURAL") 1

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WALKER GREEN

3. (b) If veteran, name war no

3. (c) Social Security No. 487-24-2714

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17  
year 1944 hour 5 minute 50 P.M.

21. I hereby certify that I attended the deceased from August 18, 1944, to June 17, 1944  
that I last saw him alive on June 17, 1944  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Addie Reed Green

6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased June 30 1912  
(Month) (Day) (Year)

Immediate cause of death:  
The peritonitis  
Pulmonary Tbc

Duration 3 days  
6mo?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 31 Months 11 Days 18  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Poplar Creek, Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Box Factory

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Joe Green

13. Birthplace Poplar Creek, Miss.  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Walker

15. Birthplace Poplar Creek, Miss.  
(City, town, or county) (State or foreign country)

Major findings: Perforated Tbc ulcer of ileum, Tbc peritonitis, enteritis, emphysema in left lung, Pulm Tbc - ulcers - cavities

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant E. McDaniel, Record Clerk  
(b) address Mo State Bldg, Mount Vernon Mo

17. (a) Removal (Burial, cremation, or removal) \_\_\_\_\_  
(b) Date thereof June 18-1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Campbell 7th

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? \_\_\_\_\_

18. (a) Signature of funeral director Geo B Carr  
(b) Address Mt Vernon Mo

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature J. F. Hayward (M. D. or other) \_\_\_\_\_  
Address Mt Vernon, Mo Date signed 6-17-44

19. (a) (Date received local registrar) \_\_\_\_\_ (b) (Registrar's signature) \_\_\_\_\_

1338

(Licensed Embalmer's Statement on Reverse Side)

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

5050

RECEIVED  
District Health Officer No. 8,  
District File Number 744-769  
Date Filed JUL 11 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.....

*Geo. B. Orr*

Licensed Embalmer No.....

*946*

P. O. Address.....

*774 Vernon 790*

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.

Registration District No. 383

Primary Registration District No. 5655

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town W. Vernon Ind.  
(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  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Walker 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 M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 20 1952  
(Month) (Day) (Year)

8. AGE: Years 3 Months 11 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Miss

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) \_\_\_\_\_ (b) Date thereof 6-18-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Geo B Cox  
18. (a) Signature of funeral director Walter Vernon  
(b) Address \_\_\_\_\_  
19. (a) 6-18-44 (b) Walter Green  
(Date 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 \_\_\_\_\_ Day \_\_\_\_\_  
Year 1954 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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

SEP 12 1944

21920