

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27089
Registrar's No. 109

FILED SEP 10 1944

Registration District No. _____
Primary Registration District No. 3002

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

1. PLACE OF DEATH:

(a) County Audrain

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

(c) Name of hospital or institution:
Mexico General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Hallie May Greenberg

3. (b) If veteran, name war None

3. (c) Social Security No None

4. Sex Female Color or race White

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

6. (b) Name of husband or wife John Greenberg

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased December 30, 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 24
If less than one day _____ hr. _____ min.

9. Birthplace Lincoln County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name J.R. Brown

13. Birthplace Lincoln County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Polly A. Brown

15. Birthplace Lincoln County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant John Greenberg

(b) Address Rush Hill, Mo.

17. (a) Burial (b) Date thereof July 25, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ladonia, Mo.

18. (a) Signature of funeral director Carl E. Pugh

(b) Address Mexico, Mo.

19. (a) Aug 4, 1944 (b) Margaret H. Mackie
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain

(c) City or town Rush Hill
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1944 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 14, 1944 to July 24, 1944
that I last saw her alive on July 24, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 7 days

Due to Hypertension

Due to Arteriosclerosis

Other conditions Fracture of R.F. Fore arm bwx
(Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 004

(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 R.B. Baigle (M.D. or other) DO
Address Ladonia Mo Date signed 7/25/44

District File Number 9-44-1535
Date Filed SEP 8 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 Earl E. Precht, Registered Apprentice No. _____ working under my personal supervision.

Signed Earl E. Precht

Licensed Embalmer No. 3189

P. O. Address Mexico, 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Sept.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Andrain
 (b) City or town Meramec
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Gen. 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

Hollie M. Greenberg

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 | 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 Dec 25 (Month) (Day) (Year)

8. AGE: Years 65 | Months 6 | Days 6 | If less than one day _____ min.

9. Birthplace Mo. (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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 July Day 24 Year 1944 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 _____ Duration _____

Acute myocarditis 7 de
Hypertension
 Due to arteriosclerosis
fracture of R. forearm 6 wks

Other conditions _____ (Include pregnancy within 3 months of death)

- Major findings: Asst **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED** **PHYSICIAN**
 Of operations _____ Underline the cause to which death should be charged statistically.
 Of autopsy HA

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence June 18, 1944
 (c) Where did injury occur? Rush Hill, Andrain, Mo. (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? In own Home
 While at work? Housework (Specify type of place) (e) Means of injury Fell on Floor

23. Signature R. B. Baize (M. D. or other) DO
 Address Laadonic Date signed 9-12-44

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

MOTHER FATHER

27089