

Registration District No. **41**

Primary Registration District No. **531**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Buchanan**
 (b) City or town **Tremont Rural**
(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 **entire life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **ROBERT CLINTON GREER**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **1**

4. Sex **MALE** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **ROSE GREER** 6. (c) Age of husband or wife if alive **64** years
 7. Birth date of deceased **May 27 1876**
(Month) (Day) (Year)

8. AGE: Years **68** Months **1** Days **20**
 If less than one day hr. _____ min. _____

9. Birthplace **Clinton Co. Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____
 12. Name **William B. Greer**
 13. Birthplace **Barnesville Ohio**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary Barnes**
 15. Birthplace **Buchanan County**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lou Greer**
 (b) Address **G. O. W. E. R. Mo.**

17. (a) **Burial** (b) Date thereof **July 19 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **New Harmony**

18. (a) Signature of funeral director **H. A. Sullivan**
 (b) Address **G. O. W. E. R. Mo.**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **17**
 year **1944** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Oct 1 1942** to **July 17 1944**
 that I last saw him alive on **1-18-44** and that death occurred on the date and hour stated above.

Immediate cause of death **coronary occlusion**
was cured 7-17-44 - but was deep when I arrived
 Due to _____

Due to _____

Other conditions **gfa**
(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 **J. C. Stearns** (M. D. or other) _____
 Address **Paris Mo** Date signed **7-19-44**

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

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

MOTHER FATHER

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.....

H. A. Sullins

Licensed Embalmer No. 1738

P. O. Address. Gouver 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.