

Registration District No. **219**

Primary Registration District No. **5786**

1. PLACE OF DEATH:

(a) County **Mississippi**
(b) City or town **Charleston, (rural)**
(c) Name of hospital or institution: **R#1**
(d) Length of stay: In hospital or institution **1**
In this community **All of life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Miss**
(c) City or town **Charleston, (rural)**
(d) Street No. **R#1**
(e) Citizen of foreign country? **No**
If yes, name country **None**

3. (a) PRINT FULL NAME **John Welton Greenlee**

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

4. Sex **M** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **0** **Infant**
6. (b) Name of husband or wife **----** 6. (c) Age of husband or wife if alive **----** years

7. Birth date of deceased **September 2nd 1944**

8. AGE: Years **0** Months **0** Days **12** If less than one day hr. **----** min. **----**

9. Birthplace **Charleston Mo**

10. Usual occupation **Infant**

11. Industry or business **----**
12. Name **Welton Greenlee**
13. Birthplace **Matthews, Missouri**
14. Maiden name **Five May Calhoun**
15. Birthplace **Crosno, Missouri**

16. (a) Informant **Welton Greenlee**
(b) Address **R#1 Charleston, Mo.**
17. (a) **Burial** (b) Date thereof **9-15-44**
(c) Place: burial or cremation **Oak Grove Charleston, Mo.**

18. (a) Signature of funeral director **[Signature]**
(b) Address **[Address]**
19. (a) **10/1/44** (b) **[Signature]**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **14th**
year **1944** hour **11** minute **30** A. M.
21. I hereby certify that I attended the deceased from **Birth**
that I last saw him alive on **Sept 12**
and that death occurred on the date and hour stated above.

Immediate cause of death **Malnutrition & dehydration**
Due to **Asplenic stenosis**

Other conditions **1579**
Major findings: **1579**
Of autopsy **1579**

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? **----**
(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 **[Signature]** (M. D. or other) **----**
Address **Charleston, Mo.** Date signed **9/20/44**

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

700

RECEIVED
District Health Office No. 2,
District File Number 1044-1420
Date Filed 10-18-44

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.....
U

Licensed Embalmer No.....

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.