

17-39
X37823

FILED DEC 7 1944

Registration District No.

Primary Registration District No. **415-8**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Dallas**
(b) City or town **Buffalo**
(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 **1**
In this community **40 years**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dallas**
(c) City or town **Buffalo**
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **16**
year **1944** hour **6** minute **45P.M.**

21. I hereby certify that I attended the deceased from **Oct 1**, 1944 to **Nov 16**, 1944
that I last saw him alive on **Nov 16**, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute heart decompensation** Duration **8 days**

Due to **Arterio Sclerosis** **20 years**

Due to **Senility**

Other conditions **Amputation of leg** **1 mo**

Major findings: Of operations **Sclerosis of vessels** PHYSICIAN

Of autopsy **None** Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (c) Means of injury

23. Signature **G. B. Plummer** (M. D. or other) **MD**
Address **Buffalo Mo** Date signed **12-1-44**

3. (a) PRINT FULL NAME **VICTOR HERVEY GREENWOOD**

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

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

6. (b) Name of husband or wife **Heta** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **Jan 20 1862**
(Month) (Day) (Year)

8. AGE: Years **81** Months **9** Days **26** If less than one day hr. min.

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

10. Usual occupation **Doctor Medicine**

11. Industry or business **Chiropractic**

12. Name **James Greenwood**

13. Birthplace **unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Amanda Lee Eiden**

15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Heta Greenwood**

(b) Address **Buffalo Mo**

17. (a) **Burial** (b) Date thereof **11-12-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clay Lawn**

18. (a) Signature of funeral director **L. B. Jones**

(b) Address **Buffalo Mo**

19. (a) **12-1-44** (b) **L. B. Jones**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

with Order No. 7,

11-44-1314

Date Filed 12-4-44

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.

Signed..... *Maxim B. Jones*

Licensed Embalmer No. *4322*

P. O. Address *Buffalo Ind.*

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. 96

Primary Registration District No. 4158

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dallam
(b) City or town Buffalo
(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 Victor H. Greenwood

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 Jan 20 1967
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 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) _____ (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 MAR 6
year 1957 hour _____ minute _____ M.

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

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Operation! was for

Due to gangrene of toes

Due to arterio-sclerosis

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

Major findings: ADDITIONAL 97

Of operations SUPPLEMENTARY

Of autopsy INFORMATION

REQUESTED

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 _____

(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)

23. Signature E. D. Hemmer (M. D. or other) MD

Address Buffalo Mo Date signed 12-16-57

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

SUPPLEMENTARY INFORMATION REQUESTED

37593