No. 2
—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 20 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6922

Registration District No. 293 Primary Registration District No. 6003 Registrar's No. 102

1. PLACE OF DEATH:

(a) County Ralls

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

(c) Name of hospital or institution: 2610 Owens Avenue (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~Marion~~ Ralls

(c) City or town Hannibal (If outside city or town limits, write "RURAL")

(d) Street No. 2610 Owens Avenue (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Matilda Jane Green

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Charles Green

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

7. Birth date of deceased January 1, 1855 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
90	xx	1	hr. min.

9. Birthplace Quincy Illinois (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name John Wingfield
13. Birthplace Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emily Shepherd
15. Birthplace No record (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. C. Binns

(b) Address 2601 Owens Hannibal Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/45 (Month) (Day) (Year)

(c) Place: burial or cremation Payson Illinois

18. (a) Signature of funeral director Wm. M. Smith

(b) Address 902 Broadway Hannibal Missouri

19. (a) 1-14-45 (Date received local registrar) (b) R. D. Berkey (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month January day 10 year 1945 hour 7 minute 20 A.M.

21. I hereby certify that I attended the deceased from -- , 19 , to -- , 19 ; that I last saw her alive on -- , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. C. Chilton (M.D. or other) M.D.

Address 500 Broadway, Hannibal, Mo. Date signed 1-12-45

1171

(Licensed Embalmer's Statement on Reverse Side)

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 George T. Bond

Licensed Embalmer No. 4373

P. O. Address Hannibal Missouri

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.

No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 293 Primary Registration District No. 6003 Registrar's No. 102

1. PLACE OF DEATH:

(a) County Ralls Clay Township

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

(c) Name of hospital or institution:
2610 Owens Avenue
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ralls

(c) City or town Hannibal
(If outside city or town limits, write "RURAL")

(d) Street No. 2610 Owens Avenue
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Matilda Jane Green

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife Charles Green

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

7. Birth date of deceased January 1, 1855 (Month) (Day) (Year)

8. AGE: Years 90 Months xx Days 1 If less than one day hr. min.

9. Birthplace Quincy, Illinois (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name John Wingfield
13. Birthplace Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emily Shepherd
15. Birthplace No record (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. C. Binns
(b) Address 2601 Owens. Hannibal, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/45 (Month) (Day) (Year)
(c) Place: burial or cremation Payson, Illinois

18. (a) Signature of funeral director Wm. M. Smith
(b) Address 902 Broadway, Hannibal, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10 year 1945 hour 12 minute 20 A M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. C. Chilton (M. D. or other) M.D.
Address 500 Broadway, Hannibal, Mo. Date signed 1/12/45

SUPPLEMENTARY

60922