

7. S. No. 2
DOM-5-43
Rev. 5-17-39
I X36671

FILED AUG 20 1945
Registration District No. **7**

Primary Registration District No. **4328**

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

1. PLACE OF DEATH:

(a) County **Mississippi**

(b) City or town **Bertrand**
(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 **8 Years**
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **John Franklin Greer**

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 **widowed**

6. (b) Name of husband or wife **Lura Greer (D)**

6. (c) Age of husband or wife if alive **1865** years

7. Birth date of deceased **July 26th** (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
79	11	14	hr. min.

9. Birthplace **Benton Co. Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **William Greer**

13. Birthplace **Benton Co. Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Ann Watson**

15. Birthplace **Benton Co. Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ada Childress**

(b) Address **Bertrand Mo.**

17. (a) Burial (b) Date thereof **7-11-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Essex, Mo.**

18. (a) Signature of funeral director *[Signature]*

(b) Address *[Address]*

19. (a) Date received local registrar **8/1/45**

(b) Registrar's signature *[Signature]*

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Miss. 67**

(c) City or town **Bertrand**
(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 **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **10th**
year **1945** hour **1** minute **15 P** M.

21. I hereby certify that I attended the deceased from **July 5**
19 **45** to **July 10** 19 **45**

that I last saw him alive on **July 10** and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Asmia	3 da
Ac. Retention	
Hypertrophy of Prostate OK.	
Senility - Arterio-sclerosis	
Major findings: Of operations: none	PHYSICIAN
Of autopsy: 1370	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? _____

23. Signature *[Signature]* (M. D. or other) _____

Address **Charleston, Mo.** Date signed **7/13/45**

RECEIVED

District Health Office No 2,

District File Number 845-1024

Date Filed 8-8-45

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

John F. Minnielee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, 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.