

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

35866

FILED OCT 24 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. 381

Primary Registration District No. 43-16

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Simpson Hospital
(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 Mo (b) County Sullivan / 0-5
(c) City or town Milan /
(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 _____

3. (a) PRINT FULL NAME Jannet Kay Green

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

4. Sex Female / 5. Color or race w
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive _____ years (Day) (Year)
7. Birth date of deceased Oct 5 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. 30 min.

9. Birthplace Milan Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Harold Keith Green
13. Birthplace Milan Mo
(City, town, or county) (State or foreign country)
14. Maiden name Amber Sue Caldwell
15. Birthplace Milan Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Keith Green
(b) Address Milan Mo

17. (a) Burial (b) Date thereof 10-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oakwood - Milan Mo

18. (a) Signature of funeral director Schoen
(b) Address 1125 S. W. 11th St. Mo

19. (a) Oct 14 - 1946 (b) Mrs. J. B. Harris
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 5
year 1946 hour 9 minute 25 M.
21. I hereby certify that I attended the deceased from Oct 5
1946 to Oct 5 1946

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

Immediate cause of death atherosclerosis Duration 5 1/2 hrs.

Due to _____

Due to _____

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

Major findings: 1601A
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury L

23. Signature J. B. Harris (M. D. or other) Dr.
Address Milan Date signed 10-6-46

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

RECEIVED
District Health Officer No. 10
District File Number 10-46-1950
Date Filed OCT 23 1946

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..... *Dwight Schaefer*

Licensed Embalmer No. *2767*

P. O. Address *Mulan 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 281

Primary Registration District No. 4515

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(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 Janet K. Green

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Oct 5 - 1930 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 30 min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(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 MO (b) County Sullivan
(c) City or town Milan (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 _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____
that I last saw him _____ above on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

35866