

No. 2
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FILED DEC 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41245**

Registration District No. **98**

Primary Registration District No. **4154**

Registrar's No. **108**

1. PLACE OF DEATH:
 (a) County **DADE**
 (b) City or town **GREENFIELD**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **NONE /**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **NONE** (Specify whether
 In this community **24 YEARS** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **DADE** **29**
 (c) City or town **GREENFIELD** **1**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **NONE** **0**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No) **0**
 If yes, name country **NONE**

3. (a) PRINT FULL NAME **ADAM YORK**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **NOVEMBER** day **29**
 year **1947** hour **7** minute **P.** M.

4. Sex **MALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **CORA YORK**
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased: **FEBRUARY 22 1851**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **June 27**
1947, to **Nov 29 1947**;
 that I last saw him alive on **November 28, 1947**
 and that death occurred on the date and hour stated above.
 Immediate cause of death: **Myocardial infarction**
Pneumonia

8. AGE: Years Months Days If less than one day
96 9 7 hr. min.

Due to **fracture of head of femur**
 Due to _____

9. Birthplace **No RECORD ALABAMA**
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **RETIRED CARPENTAR**

Major findings: Of operations

11. Industry or business **BUILDING**

Of autopsy

12. Name **No RECORD**

13. Birthplace **No RECORD 9**
 (City, town, or county) (State or foreign country)

14. Maiden name **No RECORD**

15. Birthplace **No RECORD 9**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Cora York**

(b) Address **Greenfield, Mo.**

17. (a) **BURIAL** (b) Date thereof **12-2-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **HONG CEMETERY**

18. (a) Signature of funeral director **Sam E. Sweeney**
 (b) Address **Greenfield, Mo.**

19. (a) **12-9-47** (b) **Geo. P. Wait**
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause to which death should be attributed.
10/18
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 **29**
 (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? **2**

While at work? _____ (Specify type of place) (c) Means of injury _____
 23. Signature **D. H. Jones** (M. D. or other) **JD**
 Address **Greenfield, Mo.** Date signed **12/1/47**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6;

District File Number 1247-1293

Date Filed 12-23-47

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 Sam E. Senceny Jr

Licensed Embalmer No. 4099

P. O. Address Greenfield, 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.

Registration District No. 93 Primary Registration District No. 115A

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Greenfield
(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 Adam York
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.....

7. Birth date of deceased Feb 22 1906
(Month) (Day) (Year)

8. AGE: Years 96 Months Days If less than one day
.....hr.....min.

9. Birthplace Alabama
(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) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar)..... (b) (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 July day 12 year 1947 hour..... minute..... M.

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

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) accident

(b) Date of occurrence July 12, 1947

(c) Where did injury occur? Greenfield, Dade MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home
(Specify type of place)

While at work?..... (e) Means of injury Fall

23. Signature D. W. ... (M. D. or other) MD

Address Greenfield, MO Date signed 12/18/48

SUPPLEMENTARY

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

880

or the Jones
Greenfield, Me

41245