

FILED SEP 20 1948

Primary Registration District No. **3025**

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

1. PLACE OF DEATH:

(a) County **Nowell**

(b) City or town **West Plains, mo**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community **5 yrs**  
years, months of days

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** County **Nowell**

(c) City or town **West Plains**  
(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.....

3. (a) PRINT FULL NAME **Ma. Lois Green**

(b) If veteran, name war **✓**

3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **11**  
year **1948** hour **12** minute **30 P.**

21. I hereby certify that I attended the deceased from **June 15 77**  
**1947**, to **May 11**, 19**48**;  
that I last saw her alive on **May 11**, 19**48**;  
and that death occurred on the date and hour stated above.

5. Color or race **W**

6. (a) Single, widowed, married, divorced **m-1**

6. (b) Name of husband or wife **Walter Green**

6. (c) Age of husband or wife if alive **24** years

7. Birth date of deceased **6/29-1924**  
(Month) (Day) (Year)

Immediate cause of death **Metastases of malignancy to cardiac region**

Due to **undifferentiated malignant tumor left shoulder**

Due to **axillary region**

Duration **1 week**  
**16 mo.**

8. AGE: Years **23** Months **19** Days **12** If less than one day (hr. min.)

9. Birthplace **Douglas Co. mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy **57E**

PHYSICIAN  
Underline the cause of which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name **Fred Smith**

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

14. Maiden name **Beatrice Clayton**

15. Birthplace **Douglas Co. mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter Green**

(b) Address **West Plains mo**

17. (a) **B** (Burial, cremation, or removal) (b) Date thereof **5.13.48**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Dipping Springs**

18. (a) Signature of funeral director **Robert Smith**

(b) Address **West Plains mo**

19. (a) **Sept 8-48** (Date received by local registrar)

(b) **Beatrice Cook** (Registrar's signature) **2/19**

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?..... (b) Means of injury.....

23. Signature **Virgil S. Bailey** (Physician or other)

Address **Box 191 West Plains mo** Date signed **5-25-48**

**D. B. Bailey**

RECEIVED 9-13-48  
District Health Officer No. 5,  
District File Number 548593  
Date Filed 9-14-48

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 \_\_\_\_\_  
*Robert O. Kragg* Registered Apprentice No. *432*  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. *3437*

P. O. Address *West Hill, N.Y.*

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.