

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40597

State File No.

FILED DEC 31 1948

BIRTH NO. _____ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 4258 Registrar's No. 311

52
10

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

1. PLACE OF DEATH a. COUNTY <u>Tripp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Tripp</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Edina</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 yrs.</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Edina</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Oscar</u> b. (Middle) <u>Elwin</u> c. (Last) <u>Green</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 17 1948</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 23, 1870</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>J. B. Green</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Carr</u>	14. NAME OF HUSBAND OR WIFE <u>Marcella</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (a), or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>No.</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. D. S. Riley, Edina, Mo.</u>	ADDRESS <u>Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. <u>93D</u>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>app 10 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis (Chronic)</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from Dec 7, 1948, to Dec 17, 1948, that I last saw the deceased alive on Dec 14, 1948, and that death occurred at 12:00 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>D. S. Riley M.D.</u>	23b. ADDRESS <u>Edina, Mo.</u>	23c. DATE SIGNED <u>12/18-48</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>12-19-48</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memphis</u>	24d. LOCATION (City, town, or county) (State) <u>Memphis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Dec-18-48</u>	REGISTRAR'S SIGNATURE <u>Full S. Mumart</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Kelly</u>	ADDRESS <u>General Home Edina, Mo.</u>
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RECEIVED

District Health Officer No. 10

District File Number 12-48-221

Date Filed DEC 29 1948

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 _____

Richard B. Kelly Student Embalmer No. _____
working under my personal supervision.

Signed.....
Student Embalmer

Signed Richard B. Kelly

Licensed Embalmer No. 4490

P. O. Address Eline, 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. 169

Primary Registration District No. 4258

1. PLACE OF DEATH:

(a) County KNOX
(b) City or town Edina
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County KNOX
(c) City or town Edina
(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 DORIS E. GREEN

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 _____ years

7. Birth date of deceased Aug 23
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days _____ Unless than one day
hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) Nell S. Humalt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive 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 17

S-40597