

FILED MAY 3 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12123

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>121</u>		PRIMARY REG. DIST. NO. <u>5464</u>		Registrar's No. <u>29</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Willard</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RED #1</u>		d. STREET ADDRESS (If rural, give location) <u>RED #1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Paul Hosp. Willard Mo</u>				d. STREET ADDRESS (If rural, give location) <u>RED #1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>NORMAN F.</u> b. (Middle) <u>GREENLAW</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>4-26-49</u>				
5. SEX <u>MO</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>May 27-42</u>	
9. AGE (In years last birthday) <u>6</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Calo. N.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Greenlaw</u>		13b. MOTHER'S MAIDEN NAME <u>Lena Fisher</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James Greenlaw Willard Mo</u>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory Cardiac failure</u> ANTECEDENT CAUSES DUE TO (b) <u>Other Anesthesia</u> DUE TO (c) <u>Throat Surgery</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>517X</u>					
19a. DATE OF OPERATION <u>4/26/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Chronic infection</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Willard, Greene Mo</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Willard, Greene Mo</u>		21d. HOW DID INJURY OCCUR _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u>_____</u>		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK? <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>4/26/49, 10</u> to <u>4/26/49, 19</u> , that I last saw the deceased alive on <u>4/26/49</u> , and that death occurred at <u>10:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Typed or title) <u>Dr. R. E. Wilson</u>				23b. ADDRESS <u>Willard, Mo</u>		23c. DATE SIGNED <u>4/26/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-27-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Marshfield</u>		24d. LOCATION (City, town, or county) (State) <u>Marshfield, Mo</u>	
DATE REC'D BY LOCAL REG. <u>4/29/49</u>		REGISTRAR'S SIGNATURE <u>Dr. R. E. Wilson</u>		11045. FUNERAL DIRECTOR'S SIGNATURE <u>For Family Marshfield Mo</u>		ADDRESS <u>_____</u>	

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

RE D  
RECEIVED

Greene County Health Office,

County File Number 49-35-5

Date Filed 5-2-49

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed [Signature]

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3-372

P. O. Address Waverly, 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.