

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22419

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 2000 Registrar's No. 209

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (In this place) <u>38 Days</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		d. STREET ADDRESS (If rural, give location) <u>702 E Harrison</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Grim-Smith Memorial Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Nellie Irene</u> b. (Middle) _____ c. (Last) <u>Green</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 13 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>November 30 1896</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
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13a. FATHER'S NAME <u>John W McCollum</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ratloff</u>	14. NAME OF HUSBAND OR WIFE <u>Earl Green</u> <i>202-2-Harrison Kirksville, Mo</i>
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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. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Earl Green</u> ADDRESS <u>Kirksville, 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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>  <u>171X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Squamous cell carcinoma of the</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>X</u>	19b. MAJOR FINDINGS OF OPERATION <u>X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____
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? _____

22. I hereby certify that I attended the deceased from September 19 49 to July 13, 1949, that I last saw the deceased alive on July 13, 1949, and that death occurred at 9:32 PM, from the causes and on the date stated above.

23a. SIGNATURE <u>J. P. King D. M.D.</u> (Degree or title)	23b. ADDRESS <u>Kirksville, Mo.</u>	23c. DATE SIGNED <u>7-13-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	24b. DATE <u>July 15, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Helton Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Goldsberry, Missour</u>
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DATE REC'D BY LOCAL REG. <u>7-16-49</u>	REGISTRAR'S SIGNATURE <u>Hate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Roberts</u> ADDRESS <u>Kirksville, Mo.</u>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED JUL 19 1949  
District Health Officer No. 1  
District File Number 7-49-170  
Date Filed JUL 19 1949

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 Robert B. Davis

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

Licensed Embalmer No. 4219

P. O. Address Kirksville, 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.