

FILED AUG 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 26030

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 34 PRIMARY REG. DIST. NO. 5117 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>		c. LENGTH OF STAY (in this place) <u>7 yrs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Columbia R.F.D. #4</u>		e. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia R.F.D. #4</u>	
d. STREET ADDRESS <u>R.F.D. #4</u>		f. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED a. (First) <u>GEORGE</u>		b. (Middle) _____	
c. (Last) <u>GREEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 7 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 10th 1873</u>
9. AGE (in years last birthday) <u>76</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Maggie Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Maggie Green</u> ADDRESS <u>Columbia 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Shot wound of head</u> DUE TO (b) _____ 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 _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>suicide</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home on farm</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Cedar town Boone Co</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 <u>viewed as coroner</u> , 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Darryl W. Griffith, M.D. Coroner</u>		23b. ADDRESS <u>Columbia Mo</u>	23c. DATE SIGNED <u>7-11-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>7-12-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	24d. LOCATION (City, town, or county) (State) <u>Chicago Ill.</u>
DATE REC'D BY LOCAL REG. <u>7-12-1950</u>	REGISTRAR'S SIGNATURE <u>Mrs. Mildred Burnett</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stuart Parker</u> ADDRESS <u>Columbia Mo.</u>	

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

5109

RECEIVED 8-16-50  
DISTRICT HEALTH OFFICE No. 3  
District File Number \_\_\_\_\_  
Date Filed 8-16-50

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, ~~only~~ \_\_\_\_\_

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

working under my personal supervision.

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

Signed *Stuart D. Parker* \_\_\_\_\_

Licensed Embalmer No. 2900 \_\_\_\_\_

P. O. Address *Columbia, 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.