

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 6 1952

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. Winona Registrar's No. _____

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Shannon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Carter</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Winona (rural) 3 mon</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Fremont 0180</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>home of daughter</u> | | d. STREET ADDRESS (If rural, give location) <u>/</u> | |

| | |
|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Elmer</u> b. (Middle) _____ c. (Last) <u>Greene</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 20 1952</u> |
|---|--|

| | | | | |
|-----------------|---------------------------|---|-------------------------------------|---|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>May 17 1871</u> | 9. AGE (In years last birthday) <u>80</u> If under 1 year: Months _____ Days _____ If under 1 month: Hours _____ Mins _____ |
|-----------------|---------------------------|---|-------------------------------------|---|

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>livestock</u> | 11. BIRTH PLACE (State or foreign country) <u>Ill</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|--|---|--|

| | | |
|--|--|--|
| 13a. FATHER'S NAME <u>John L. Greene</u> | 13b. MOTHER'S MAIDEN NAME <u>Eveline Edgeman</u> | 14. NAME OF HUSBAND OR WIFE <u>Margaret Greene</u> |
|--|--|--|

| | | | |
|---|-----------------------------------|---|-------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> | 16. SOCIAL SECURITY NO. <u>no</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Rovena Greene West Plains Mo</u> | ADDRESS <u>West Plains 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>See qrs</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Heart failure - Morbid Con.</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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? <u>410X</u> YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------------|--|--|

| | | |
|--|--|---|
| 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) _____ | 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 May, 1957, to 2/20, 1952, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:00 A m., from the causes and on the date stated above.

| | | |
|---|-----------------------------------|---------------------------------|
| 23a. SIGNATURE <u>J. N. Cotton M.D.</u> (Degree or title) | 23b. ADDRESS <u>Van Buren, Mo</u> | 23c. DATE SIGNED <u>2/21/52</u> |
|---|-----------------------------------|---------------------------------|

| | | | |
|---|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>2-24-52</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Eveline</u> | 24d. LOCATION (City, town, or county) (State) <u>Carter Co Mo</u> |
|---|--------------------------|---|---|

| | | | |
|---|---|---|---------------|
| DATE REC'D BY LOCAL REG. <u>MAR 20 1952</u> | REGISTRAR'S SIGNATURE <u>Elyse H. Briffet</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Seaton Perwit</u> | ADDRESS _____ |
|---|---|---|---------------|

8.5, (Signed Embalmer's Statement on Reverse Side)

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

010

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.

Student
Student Embalmer

Signed: Seaton Pewitt

Licensed Embalmer No. 2287

P. O. Address Van Buren 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.