

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1969

FILED FEB 9 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 164 PRIMARY REG. DIST. NO. 2032 Registrar's No. 21

1510

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

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Warrensburg		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Warrensburg Mo. 1512	
c. LENGTH OF STAY (If this place) 25 Yrs		d. STREET ADDRESS (If rural, give location) 307 S. Warren	
d. FULL NAME OF HOSPITAL OR INSTITUTION Warrensburg Medical Center			

3. NAME OF DECEASED (Type or Print) Mattie Moore Greenwell			4. DATE OF DEATH Jan. 28 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	
8. DATE OF BIRTH Dec. 17 1866		9. AGE (In years last birthday) 86		10. UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Johnson Co. Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A					

13a. FATHER'S NAME James Dyer		13b. MOTHER'S MAIDEN NAME Mary R. Greer		14. NAME OF HUSBAND OR WIFE R. W. Greenwell Dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rice Greenwell Warrensburg Mo.	

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 1 wk 2 wks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, bronchial		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Influenza 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 480x		20. AUTOPSY? 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?	

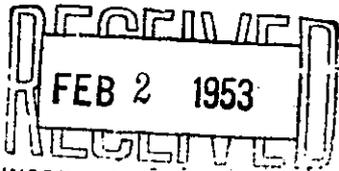
22. I hereby certify that I attended the deceased from Nov 1951, to 28 Jan, 1953, that I last saw the deceased alive on 24 Jan, 1953, and that death occurred at 9 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D.		23b. ADDRESS Warrensburg Missouri		23c. DATE SIGNED 1-31-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-30-53		24c. NAME OF CEMETERY OR CREMATORY Columbus Cem.		24d. LOCATION (City, town, or county) (State) RED Centerview Mo.	
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DATE REC'D BY LOCAL REG. Jan. 31, 1953		REGISTRAR'S SIGNATURE Savannah C. Phillips		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sweeney Phillips Warrensburg Mo.	
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(Licensed Embalmer's Statement on Reverse Side)



JOHNSON COUNTY HEALTH DEPT.

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

*P. Q. Phillips*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2320*

P. O. Address *Warrensburg 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.