

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23943

State File No.

FILED AUG 10 1953

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>841</u>			
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>46 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Rural</u>		<u>0110</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Wyatt Park Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>R. R. #4</u>					
3. NAME OF DECEASED (Type or Print) <u>Emma</u>			a. (First) <u>J.</u>		c. (Last) <u>Greene</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 31, 1953</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>February 10, 1868</u>		9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months	IF UNDER 2 WKS. Days	Hour	Min.
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 <u>own home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Oltman Johnson</u>			13b. MOTHER'S MAIDEN NAME <u>unk.</u>		14. NAME OF HUSBAND OR WIFE <u>Edwin H. Greene</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Leon Bauer, R.R. #4, St. Joseph, 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>Congestive heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
		ANTECEDENT CAUSES DUE TO (b) <u>Cerebral vascular accident</u>					<u>10 days</u>		
		DUE TO (c) <u>Arteriosclerotic heart disease</u>					<u>years</u>		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of subtrachanteric femur (left)</u>					<u>3 months</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION: <u>4200 F</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>Nursing Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph, Buchanan, Missouri</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>4-21-53 7AM</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Slipped and fell</u>					
22. I hereby certify that I attended the deceased from <u>1946</u> , 19 <u> </u> , to <u>July 31</u> , 19 <u>53</u> that I last saw the deceased alive on <u>7-31-</u> , 19 <u>53</u> , and that death occurred at <u>6:15a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>E. H. Anderson</u>			(Degree or title) <u>M. D.</u>		23b. ADDRESS <u>311 Physician & Surgeons Bldg., St. Joseph, Mo.</u>		23c. DATE SIGNED <u>7-31-53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>8/3/1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>				
DATE REC'D BY LOCAL REG. <u>Aug. 1, 1953</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>485-0</u> <u>Heaton-Brown Funeral Home</u> <u>St. Joseph, Mo.</u>					

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

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 Eugene Wood
Licensed Embalmer No. 3804

P. O. Address 314 So 10th St. Joseph, 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.