

11137

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 270

RN-8748

XC-164 85 68

FILED APR 28 1955

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>3007</u>	
1. PLACE OF DEATH a. COUNTY <u>Butler</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u>		c. LENGTH OF STAY (In this place) <u>1 day</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Success</u>		8.420
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VA Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>8</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>ORIN</u> b. (Middle) <u>BENJAMIN</u> c. (Last) <u>GREEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 10, 1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Oct. 23, 1894</u>	9. AGE (In years last birthday) <u>60</u>	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apiculture</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hitzville, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>ORIN J. GREEN</u>		13b. MOTHER'S MAIDEN NAME <u>MAGGIE M. DENNIS</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT'S SIGNATURE OR NAME <u>VA HOSPITAL RECORDS</u> ADDRESS _____		
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>Generalized peritonitis and sepsis</u>		INTERVAL BETWEEN ONSET AND DEATH
			ANTECEDENT CAUSES DUE TO (b) <u>Strangulated left spigelian hernia with perforated bowel.</u> DUE TO (c) <u>Suspected pulmonary embolism</u>		
			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Obstruction vascular supply to left</u>		
19a. DATE OF OPERATION <u>April 9, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>lower extremity. Spigelian hernia, strangulated-perforated bowel, peritonitis</u>			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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) <u>5615</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>VA</u> m. _____		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>April 9, 1955</u> , to <u>April 10, 1955</u> , XXXXXX and that death occurred at <u>3:20 p.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>Charles W. Gaskins, M.D. Chief Surg. Ser.</u> (Degree or title) _____		23b. ADDRESS <u>VA Hospital Poplar Bluff, Mo.</u>		23c. DATE SIGNED <u>4-11-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-14-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>National Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Jefferson County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4/18/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> ADDRESS _____		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Poplar Bluff, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
APR 25 1955
BUTLER CO. HEALTH CENTER
FILE No. _____

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 4-10

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Phil A. Leuchter

Licensed Embalmer No. _____

2936

P. O. Address _____

Maple Bluff

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.