

FILED OCT 17 1955

STANDARD CERTIFICATE OF DEATH

34384

State File No.

BIRTH NO. REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 245

1. PLACE OF DEATH
 a. COUNTY Randolph
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Madison
 c. LENGTH OF STAY (in this place)
 d. FULL NAME OF HOSPITAL OR INSTITUTION Madison Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
 a. STATE Mo b. COUNTY Madison
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Callas Rural
 d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED
 a. (First) John b. (Middle) Loy c. (Last) GREEN
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year) 10-5-55
 5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
 8. DATE OF BIRTH 7-2-67 9. AGE (In years last birthday) 88
 If under 1 year: Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
 10b. KIND OF BUSINESS OR INDUSTRY
 11. BIRTHPLACE (State or foreign country) Barnville Mo
 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Bunnels Green 13b. MOTHER'S MAIDEN NAME Clyde 14. NAME OF HUSBAND OR WIFE Marion Mustle Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No
 16. SOCIAL SECURITY NO. 4200
 17. INFORMANT'S SIGNATURE OR NAME Mustle Green ADDRESS Callas 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.
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease
 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? YES 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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1st, 1955, to Oct 5th, 1955, that I last saw the deceased alive on Oct 5th, 1955, and that death occurred at 9 PM m., from the causes and on the date stated above.

23a. SIGNATURE John S. Fleming M.D. (Degree or title)
 23b. ADDRESS Moberly, Mo
 23c. DATE SIGNED 10-8-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
 24b. DATE 10-8-55
 24c. NAME OF CEMETERY OR CREMATORY Locust Grove Ch
 24d. LOCATION (City, town, or county) (State) Callas Mo

DATE REC'D BY LOCAL REG. 10-8-55
 REGISTRAR'S SIGNATURE Leah Loue 269-
 25. FUNERAL DIRECTOR'S SIGNATURE W. E. Edwards ADDRESS Beris Mo

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

H. A. Edwards

Licensed Embalmer No.

1961

P. O. Address

Bowie, 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.