

FILED NOV 17 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37754**

BIRTH NO.		REG. DIST. NO. <b>278</b>	PRIMARY REG. DIST. NO. <b>3054</b>	Registrar's No. <b>116</b>
1. PLACE OF DEATH a. COUNTY <b>Pike</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Pike</b>		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Louisiana</b> )		c. LENGTH OF STAY (in this place) <b>1944</b>	c. CITY OR TOWN <b>Louisiana</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
3d. FULL NAME OF HOSPITAL OR INSTITUTION <b>209 No. 8th</b>		STREET ADDRESS (If rural, give location) <b>209 No. 8th 082/0</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Claude</b>		b. (Middle) <b>E.</b>	c. (Last) <b>Green</b>	
4. DATE OF DEATH (Month) <b>11</b> (Day) <b>6</b> (Year) <b>55</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept 30-1882</b>	9. AGE (in years last birthday) <b>73</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 1 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>FRANKFORD, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <b>MAGGIE LEE WILSON</b>	13c. NAME OF HUSBAND OR WIFE <b>IDA GREEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-34-7557</b>	17. INFORMANT'S SIGNATURE OR NAME <b>IDA GREEN, LOUISIANA, MO</b> 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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Cerebro-Vascular Accident (apoplexy)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Arterio-Sclerotic Cardio Vascular Disease 4 years</b>		
		DUE TO (c) <b>Chr. Myocarditis + Cardiac Hypertrophy 5 years</b>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4221</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <b>July 15, 1955</b> , to <b>Nov. 6, 1955</b> , that I last saw the deceased alive on <b>Nov. 5, 1955</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.				
23a. SIGNATURE <b>Robert L. Andrae M.D.</b> (Degree or title)		23b. ADDRESS <b>Louisiana No. 117/55</b>		23c. DATE SIGNED <b>11/7/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>Nov. 8, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>BOWLING GREEN CEM. - BOWLING GREEN, MO</b>	24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <b>Nov 8, 1955</b>	REGISTRAR'S SIGNATURE <b>Bernice Callier</b>	25. GENERAL DIRECTOR'S SIGNATURE <b>Geo. M. Callier</b>	ADDRESS <b>Louisiana, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

DEC 21 1956

MAY 20 1956

NOV 1 1956

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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.