

Health,
Welfare
Public
Service

FILED APR 1 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14720-58

58-009254
STATE FILE NUMBER

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 42

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-57

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|--|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Clinton</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission: <u>0251</u>) a. STATE _____ b. COUNTY _____ | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAMERON</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN _____ | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hosp.</u> | | Length of stay in 1b _____ | d. STREET ADDRESS (If outside, give location) _____ | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle _____ Last <u>GREEN</u> | | | 4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 17 1958</u> | | 9. AGE (In years last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and state or country) <u>CAMERON MISSOURI</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Erskine Green Jr.</u> | | 13b. MOTHER'S MAIDEN NAME <u>Othelia E. Tate</u> | |
| 14. NAME OF HUSBAND OR WIFE _____ | | 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 <u>Erskine Green Jr.</u> | | Address <u>Plattsburg Mo.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>compression of cord</u> DUE TO (c) <u>Breech delivery</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>0</u> | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. CITY, TOWN, OR LOCATION <u>Plattsburg</u> | | COUNTY _____ | | STATE _____ | |
| 21. I attended the deceased from <u>birth</u> to <u>death</u> and last saw ^{him} her alive on <u>March 17, 1958</u> Death occurred at <u>113 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>D. W. Hayward D.O. 2</u> | | | 22b. ADDRESS <u>Plattsburg Mo.</u> | | 22c. DATE SIGNED <u>3/24/58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>3/18/1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. Washington</u> | | 23d. LOCATION (City, town, or county) (State) <u>Plattsburg MO.</u> |
| 24. FUNERAL DIRECTOR <u>A. D. Lyon</u> | | ADDRESS <u>Plattsburg MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-25-58</u> | 26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature. All diseases in Part I must be causally related.

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~~ *Prepared for burial By me*, Student Embalmer No.

working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Phillip E. Col*

Licensed Embalmer No. *4493*
P. O. Address *Stonington, N*

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.