

t. Health,  
& Welfare  
S. Public  
th Services

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032475

STATE FILE NUMBER

FILED OCT 1 1958 Registration District No. 38240 Primary Registration District No. 4230 Registrar's No. 19

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Armstrong, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Armstrong 0458</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pierce Rest Home</b>		Length of stay in lb <b>15 Months</b>	d. STREET ADDRESS <b>R.R.</b> (If outside, give location)
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>MORRIS</b> Last <b>GREEN</b>			4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1874</b>
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>Self</b>	9. AGE (In years last birthday) <b>84</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ IF UNDER 24 HRS. Min. _____
11. BIRTHPLACE (City and state or country) <b>Howard County, Missouri</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Franklin Green</b>		13b. MOTHER'S MAIDEN NAME <b>Bettie Morris</b>	
14. NAME OF HUSBAND OR WIFE <b>-6-----</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, to or unknown) (If yes, give war or dates of service) <b>No.</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Dave Green, Armstrong, Missouri</b> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE	
21. I attended the deceased from Death occurred at <b>July 1958</b> to <b>Aug 27 58</b> and last saw her/him alive on <b>Aug 26, 1958</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>M. P. Reed, M.D.</b>		22b. ADDRESS <b>Fayette, Mo</b>	
22c. DATE SIGNED <b>9/1/58</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/29/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sharon Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Howard County, Missouri</b>
24. FUNERAL DIRECTOR <b>Fayetta Carr</b> ADDRESS <b>Fayette, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Sept 20, 1958</b>	
26. REGISTRAR'S SIGNATURE <b>Walker Audsley</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Donald L. Kabe .....

Licensed Embalmer No. 4722 .....

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