

Health,
& Welfare
Public
Service

5. 300
v. 1-57

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.

FILED OCT 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035613

STATE FILE NUMBER

XC-4126664

REG. #17260

Registration District No. 43

Primary Registration District No. —

Registrar's No. 913

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		c. CITY OR TOWN BENTON	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL		Length of stay in 1b 9 DAYS	
3. NAME OF DECEASED (Type or print) First WADE Middle "C" Last GREER		4. DATE OF DEATH OCTOBER 7, 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) CANALOU, MISSOURI
13a. FATHER'S NAME HIRAM GREER		13b. MOTHER'S MAIDEN NAME LOLA WESTERFIELD	14. NAME OF HUSBAND OR WIFE MYRTSE GREER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) CORONARY ARTERIOSCLEROSIS. DUE TO (c) 4201			INTERVAL BETWEEN ONSET AND DEATH 9 Days. Several Yrs.
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Sept. 28, 1958 to October 7, 1958 Death occurred at 4:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Medical Svc.		22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 10/7/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-9-58	23c. NAME OF CEMETERY OR CREMATORY Garden of Memories	23d. LOCATION (City, town, or county) (State) Sikeston, Missouri
24. FUNERAL DIRECTOR Phyllis J. Cassel ADDRESS Nunneles Funeral Chapel Sikeston Mo.		25. DATE RECD. BY LOCAL REG. 10/11/58	26. REGISTRAR'S SIGNATURE [Signature]

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

855i 8 AUM

RECEIVED

OCT 21 1958
BUTLER CO. HEALTH CENTER

FILE No. _____

NOV 3 1958

OCT 27 1958

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 *Philip J. Cassidy* _____

Licensed Embalmer No. *4618* _____
P.O. Address *Sebaston, 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.