

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037113

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3047 Registrar's No. 327

REC'D OCT 20 1958

S. 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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence, 413 Olive</u>			Length of stay in 1b		064 ¹ / ₂ STREET ADDRESS <u>413 Olive</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>GREEN</u> Last <u>GREEN</u>				4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1958</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 1, 1882</u>		9. AGE (In years last birthday) <u>75</u>		10. UNDER 1 YEAR Months <u>11</u> Days <u>7</u>		11. UNDER 24 MRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>St. Marys Pharmacy</u>		11. BIRTHPLACE (City and state or country) <u>Pickering Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13a. FATHER'S NAME <u>Frank Green</u>				13b. MOTHER'S MAIDEN NAME <u>Mary Vinzant</u>				14. NAME OF HUSBAND OR WIFE <u>Ruby Ritchie Green</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>488 24 8058</u>		17. INFORMANT Address <u>Mrs. Frank Green, Hannibal Missouri</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>Coronary Thrombosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____													
DUE TO (c) _____										<u>4201</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 checked="" 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.)										
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			COUNTY		STATE		
21. I attended the deceased from <u>2-20-55</u> to <u>10-8-58</u> and last saw ^{her} him alive on <u>10-8-58</u> Death occurred at <u>3:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>0</u>						22b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>			22c. DATE SIGNED <u>10-10-58</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/10/1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>			23d. LOCATION (City, town, or county) <u>Hannibal Missouri</u>			(State)			
24. FUNERAL DIRECTOR <u>W. Crawford Smith, Hannibal Missouri</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-13-1958</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

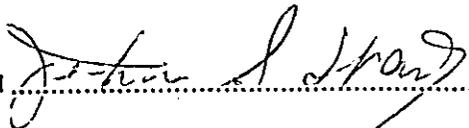
H.C. Fisher

RECEIVED OCT 17 1958
MARION CO. HEALTH DEPT.
DATE FILED OCT 17 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 

Licensed Embalmer No. 4540
P. O. Address Hannibal Missouri

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.