

Health,
& Welfare
Service

FILED FEB 16 1959
IC-4540016
REG.#A193

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000394

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 68

300
1-57

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		c. CITY OR TOWN CORNING	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) ROUTE TWO	

3. NAME OF DECEASED (Type or print) First EDDIE Middle FRANKLIN Last GREEN			4. DATE OF DEATH FEBRUARY 1, 1959 Month Day Year		
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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 5-23-16	9. AGE (In years last birthday) 42	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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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) CLINTON, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ELMER E. GREEN	13b. MOTHER'S MAIDEN NAME CORA GORDON	14. NAME OF HUSBAND OR WIFE MINNIE V. GREEN
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL.		INTERVAL BETWEEN ONSET AND DEATH 3-4 Weeks.
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DUE TO (b) BRONCHIECTASIS, CHRONIC, LOWER LUNG FIELDS.		28 Years
DUE TO (c) 526x few		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. Cor Pulmonale with congestive heart failure. 2. Surgical absence, right middle & lower lobes of lung. 3. Exhaustion state.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)	
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		
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20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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
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21. attended the deceased from Jan. 31, 1959 to Feb. 1, 1959 Death occurred at 4:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE Robert S. Cohen (Do not sign if not a physician) ROBERT S. COHEN, M.D., Chief, Medical Svc. VA HOSPITAL, POPLAR BLUFF, MO.	22b. ADDRESS	22c. DATE SIGNED 2/2/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/3/59	23c. NAME OF CEMETERY OR CREMATORY Mars Hill Cemetery	23d. LOCATION (City, town, or county) (State) Rt. #2 Corning, Ark.
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24. FUNERAL DIRECTOR ADDRESS Mowery Funeral Svc. Piggott, Ark	25. DATE RECD. BY LOCAL REG. 2/7/59	26. REGISTRAR'S SIGNATURE R. M. Wheeler
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Secretary, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Serial -
87-100-3

FILE NO.

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 *Kenneth W. Mowery*

Kenneth W. Mowery
Licensed Embalmer No. 1087
P. O. Address Piggott, Arkansas

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.