

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001318

STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 172

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette			
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Mayview		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Kansas City, Mo				Length of stay in 1b 61 days		d. STREET ADDRESS (If outside, give location) 5 mi S 40-Ville	
3. NAME OF DECEASED (Type or print) First John Middle C. Last Greer				4. DATE OF DEATH Month 1 Day 11 Year 59			
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 5-20-1875	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming				10b. KIND OF BUSINESS OR INDUSTRY agriculture		9. AGE (In years last birthday) 83	
13. FATHER'S NAME James Greer				14. MOTHER'S MAIDEN NAME Sadie Petty		11. BIRTHPLACE (City and state or country) Missouri	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 495-42-6654		12. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT Mrs Bertie Greer, Mayview, Mo. R 1				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) <i>Arteriosclerotic Heart Disease</i>						INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (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)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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.) 42	
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 <i>Nov. 10, 1958</i> to <i>Jan 10, 1959</i> and last saw ^{her} him alive on <i>Jan 11, 1959</i> Death occurred at <i>1:15 p. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Donald Mc Farland M.D.</i>				22b. ADDRESS <i>315 Nichols Rd</i>		22c. DATE SIGNED <i>1/12/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-14-59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Odessa Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Odessa Missouri</i>	
24. FUNERAL DIRECTOR <i>Ralph O. Jones</i>				25. DATE RECD. BY LOCAL REG. <i>1-11-59</i>		26. REGISTRAR'S SIGNATURE <i>neva menishall</i>	

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
M. Donald Mc Farland

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 *Ralph C. Jones*.....

Licensed Embalmer No. *46*

P. O. Address *Odessa*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.