

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 17 1959

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STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 147

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ft Leonard Wood, Missouri</b>		Length of stay in 1b <b>DOA</b>		c. CITY OR TOWN <b>Palace</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>US Army Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>-</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MERLIN</b> Middle <b>DARWIN</b> Last <b>GREENWAY JR.</b>				4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</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>July 16, 1957</b>	9. AGE (last birthday) <b>2</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>Fort Bragg, N.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Merlin D. Greenway</b>			13b. MOTHER'S MAIDEN NAME <b>Bernice Fausett</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>-</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Merlin D. Greenway</b>		
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>Respiratory Failure</b> DUE TO (b) <b>2° Atrophy brain, Congenital</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____							
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 <b>USAH, Ft Leonard Wood, Missouri</b>		COUNTY	STATE
21. I attended the deceased from <b>November 21 1959</b> to <b>November 21, 1959</b> and last saw <sup>her</sup> him alive on <b>DOA</b> Death occurred at <b>pronounced dead 8:55 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>HANS H. BARUCH, Captain, MC</b>				22b. ADDRESS <b>USAH, Ft Leonard Wood, Missouri</b>		22c. DATE SIGNED <b>Nov 21, 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>		23b. DATE <b>11-22-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>mound</b>		23d. LOCATION (City, town, or county) (State) <b>Near New Madrid - Mo.</b>		
24. FUNERAL DIRECTOR <b>Earl W. Craig</b>			ADDRESS <b>14th Ave</b>	25. DATE RECD. BY LOCAL REG. <b>12-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Eula Mae Anderson</b>		

RECEIVED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Lowell C. Craig

Licensed Embalmer No. 4766

P. O. Address Mt. Grove

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.