

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 13 1960

-60-002433

STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		c. CITY OR TOWN <u>MARCELINE</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>ST. FRANCIS HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>619 E. SANTA FE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>VENICE</u> Last <u>GREEN</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>3</u> Year <u>1960</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>JULY 9 1899</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>24</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ATSF RLWY.</u>		11. BIRTHPLACE (City and state or country) <u>MARCELINE Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>HUGH GREEN</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA STANLEY</u>		14. NAME OF HUSBAND OR WIFE <u>MARIAN GREEN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>709-14-2909</u>		17. INFORMANT Address <u>Mrs. Howard Jean Marceline Mo.</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) Carcinoma Lung & Hemorrhage
DUE TO (b) and Cardiac Vascular Collapse
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.
 Yes No Unknown

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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 1950 to 1-3-60 and last saw her/him alive on 1-2-60
Death occurred at 7:30 0 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert W. Lewis MD</u> (Degree or title)		22b. ADDRESS <u>Marceline, MO</u>		22c. DATE SIGNED <u>1-5-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-6-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVE CEM</u>	23d. LOCATION (City, town, or county) (State) <u>MARCELINE Mo.</u>	

24. FUNERAL DIRECTOR <u>M. HER-Tillotson</u>		ADDRESS <u>MARCELINE</u>		25. DATE RECD. BY LOCAL REG. <u>1-5-60</u>	26. REGISTRAR'S SIGNATURE <u>Bavonia Owens</u>
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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 Leburn K. Tildate

Licensed Embalmer No. 4508

P. O. Address Marcell

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.