

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015064

FILED VS MAY 2 1960

140

Primary Registration District No. 3024

Registrar's No. 44

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette</b>		Length of stay in 1b <b>30 min.</b>		c. CITY OR TOWN <b>Armstrong</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lee Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>112 W. Halley St.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>AUBRA</b> Middle <b>MARTIN</b> Last <b>GREEN</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/16/1883</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (City and state or country) <b>Howard Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John Nelson Green</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Woods</b>		14. NAME OF HUSBAND OR WIFE <b>Edna Mae Yancey</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>491-28-9390</b>	17. INFORMANT Address <b>Mrs A. M. Green Armstrong, Mo</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>Cerebral vascular thrombosis</b> DUE TO (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>unknown</b>
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 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 <b>Jan 1947</b> to <b>April 27 1960</b> and last saw him alive on <b>4-27-60</b> Death occurred at <b>3:30 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>James J. Allen M.D.</b>				22b. ADDRESS <b>Fayette, Mo</b>		22c. DATE SIGNED <b>4-29-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/29/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Chapel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Armstrong, Missouri</b>			
24. FUNERAL DIRECTOR <b>Ralph A. Case</b>			ADDRESS <b>Fayette, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>4-29-60</b>	26. REGISTRAR'S SIGNATURE <b>Katherine Welch</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

