

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028809  
STATE FILE NUMBER

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 136

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

**FILED AUG 29 1961**

1. PLACE OF DEATH  
a. COUNTY Dunklin  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kennett Length of stay in 1b hours  
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Dunklin Co. Memorial Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Arkansas b. COUNTY Clay  
c. CITY OR TOWN Rector, Route 1 Inside Limits Yes  No   
d. STREET ADDRESS (If outside, give location) Rector, Route 1 Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year  
Calvin Wall Green August 16 1961

5. SEX Male 6. COLOR OR RACE White 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH Feb. 29, 1880 9. AGE (last birthday) 81 IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

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) Arkansas 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Kater Green 13b. MOTHER'S MAIDEN NAME Mollie Griffin 14. NAME OF HUSBAND OR WIFE Ada Lovelady Green

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. Unknown 17. INFORMANT Albert Green, Rector, Ark. 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) Perforated stomach ulcer INTERVAL BETWEEN ONSET AND DEATH  
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)  
PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  N:  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  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  NOT WHILE AT WORK  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 Jan 1961 to Aug 1961 and last saw her/him alive on Aug. 14, 1961  
Death occurred at 3 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) D. H. Cefo Lon M.D. 22b. ADDRESS Rector, Ark 22c. DATE SIGNED 8/19/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 8-17-61 23c. NAME OF CEMETERY OR CREMATORY Woodland Heights 23d. LOCATION (City, town, or county) (State) Rector, Arkansas

24. FUNERAL DIRECTOR Irby Funeral Home, Rector, Ark. ADDRESS 8-21-1961 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE Carl Husband

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.