SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-041731
STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 388

FILED NOV 21 1961

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal — Length of stay in 1b: 17 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Marion
c. CITY OR TOWN Hannibal — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 400 Grand Ave. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Freda Middle: S. Last: Greening
4. DATE OF DEATH Month: Nov Day: 1 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-3-1894
9. AGE (last birthday): 67 — 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): Housework (Own)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Carrolton, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: James S. Anderson
13b. MOTHER'S MAIDEN NAME: Mattie Belle Preston
14. NAME OF HUSBAND OR WIFE: C.E. Greening
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dewey Greening — Address: Hannibal, Mo.

INSTEAD OF

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia, a~~lso diabetis mellitus~~ Yes. — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic vascular disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Diabetes Mellitus.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ 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 10-15-61 to 11-1-61 and last saw her alive on 11-1-61
Death occurred at 8:10 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert J. Lanning M.D. (Degree or title)
22b. ADDRESS 115 North Fifth St. Hannibal, Mo.
22c. DATE SIGNED 11-7-61

DOCUMENT

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov 4 1961
23c. NAME OF CEMETERY OR CREMATORY: Stoutsville Cemetery
23d. LOCATION (City, town, or county) (State): Stoutsville, Mo.

ITEM NO. SHOULD READ

24. FUNERAL DIRECTOR: Clark Funeral Home — ADDRESS: Hannibal, Mo.
25. DATE RECD. BY LOCAL REG.: 11/9/61
26. REGISTRAR'S SIGNATURE: Dr. E. M. Lucke by Lillian M. Herman

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

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 G. Clark

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo.

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.