

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-000612

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 53

AMENDED

FILED JAN 29 1962

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CAPE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>	Length of stay in 1b <u>8 yrs.</u>	c. CITY OR TOWN <u>CAPE GIRARDEAU</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>1600 Bloomfield St</u>		d. STREET ADDRESS (If outside, give location) <u>1600 Bloomfield St</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARION J. GREER</u>			4. DATE OF DEATH Month Day Year <u>JAN. 14, 1962</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-1875</u>	9. AGE (last birthday) <u>86</u>	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) <u>FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOLLINGER CO.</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		

13a. FATHER'S NAME <u>Levi Greer</u>	13b. MOTHER'S MAIDEN NAME <u>MARY Sitze</u>	14. NAME OF HUSBAND OR WIFE <u>LAURA</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>No</u>	17. INFORMANT Address <u>Ms. J. L. Soebel Cape Gir. Mo</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>		<u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>		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	COUNTY STATE

21. I attended the deceased from Nov 01 to 14 Jan 62 and last saw her alive on 14 Jan 62.  
Death occurred at 6:15 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. W. Ashley</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Cape Girardeau Mo</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-16-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OLD TRACE CREEK</u>
24. FUNERAL DIRECTOR <u>Gene Ward, Lutesville mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-23-62</u>	26. REGISTRAR'S SIGNATURE <u>James Kasten</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 R. O. Laine

Licensed Embalmer No. 4538

P. O. Address Jackson, 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.