

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043387  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 237

VS 300  
Rev. 4/59

0595

205-80

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Livingston</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Length of stay in 1b <u>3 months</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Susan Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> c. CITY OR TOWN <u>New Boston</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (if outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL GREENSTREET</u>		4. DATE OF DEATH Month Day Year <u>November 21, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/1904</u>
9. AGE (last birthday) <u>58</u> IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer any kind of work</u>	
11. BIRTHPLACE (City and state or country) <u>New Boston, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William F. Greenstreet</u>		13b. MOTHER'S MAIDEN NAME <u>Emma V. Carricker</u>	
14. NAME OF HUSBAND OR WIFE <u>None</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>unknown</u>		17. INFORMANT <u>Arthur B. Greenstreet, Kirkville, Mo.</u> 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) <u>Acute coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> DUE TO (b) <u>arteriosclerosis</u> ? Conditions: if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>hypercholesterolemia</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>compensatory heart failure - paralysis of left side of body</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 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 <u>Aug-1962</u> to <u>Nov-1-62</u> and last saw <sup>her</sup> him alive on <u>Nov 21, 62</u> Death occurred at <u>210 8</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write title) <u>Joseph F. Gale M.D.</u>		22b. ADDRESS <u>Chillicothe, Mo</u>	
22c. DATE SIGNED <u>11-27-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 25, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wilton Advent Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Missouri</u>	
24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>Nov 24, 1962</u>	
		26. REGISTRAR'S SIGNATURE <u>Annalce Taylor</u>	

(Licensed Embalmer's Statement on Reverse Side)

FILED 1930

**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 B. Lindley  
Licensed Embalmer No. 11822

P. O. Address Chillicothe 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.