Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

75

Washington State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

Record No.

County of Yakima

Registered No. 26

City or Town of North Yakima

Registration Dist. No. ______ (No. St Elizabeth Hospital St., ______ Ward)

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

[If death occurs away from USUAL RESIDENCE give facts called for under Item 18.]

FULL NAME Charley L. Greene 650

Personal and Statistical Particulars

3 Sex: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (Write the word): Married

6 Date of Birth: June (Month) 19 (Day), 1853 (Year)

7 Age: 63 yrs. 7 mos. 12 ds. If LESS than 1 day, ___ hrs. or ___ min.?

8 Occupation (a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): ______

9 Birthplace (State or country): New York

PARENTS

10 Name of Father: Oliver Greene

11 Birthplace of Father (State or country): New York

12 Maiden name of Mother: Louisa Coon

13 Birthplace of Mother (State or country): New York

14 The above is true to the best of my knowledge

(Informant) Mrs Charley Greene

(Address) R F D. Wapato

15 Filed 2-3-, 1917 B. S. Cresswell, Registrar.

Medical Certificate of Death

16 Date of Death: Feb (Month) 1 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1916, to Feb 1", 1917, that I last saw him alive on Feb 1" 1917 and that death occurred, on the date above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute exacerbation of chronic nephritis & myocarditis

30 (Duration) 3 yrs. ___ mos. 6 ds.

Contributory (Secondary): Operation for Appendectomy Cholecystect

(Duration) ___ yrs. ___ mos. 8 ds.

(Signed) Paul B. Cooper, M. D.

2/2, 1917 (Address) N Yakima

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)

At Place of death ___ yrs. ___ mos. 15 ds. In the State 40 yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? Wapato, Wash

Former or usual residence: Near Wapato, Wash

19 Place of Burial or Removal: Tahoma Cem

Date of Burial: Feb 4, 1917

20 Undertaker: Shaw & Sons

Address: N Yakima Wn

I HEREBY CERTIFY, That I have been unable to secure answers to Questions ______ (Insert numbers of unanswered questions)

______ (Signature of Undertaker)

[Approved by U. S. Census and American Public Health Association.]

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e.g., Farmer or Planter, Physician,

spinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of...... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.