MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

3219

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 1818

City St Louis, Mo (No. City Hosp No 2, ... St. ..... Ward)

2. FULL NAME Baby Green

(a) Residence. No. 14 39 Webster St., 26 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.

4. COLOR OR RACE: negro.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): —

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1, 1927

7. AGE: YEARS | MONTHS | DAYS: 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Walter Green

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss.

12. MAIDEN NAME OF MOTHER Anna White

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED JAN 24 1927 19 Mark C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 3, 1927, that I last saw him alive on Jan 3, 1927, and that death occurred, on the date stated above, at 5 35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia

Primary

107A

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY) 1000

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J W Gray, M. D

, 19 (Address) City Hosp. No 2

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: POTTERS FIELD.

DATE OF BURIAL: 1-27-1927

20. UNDERTAKER: J. H. Trotter

ADDRESS: 2945 Lawton Av.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.