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

Do not use this space.

File No. 28989

Registered No. 8572

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1093

City St. Louis Mo. (No. 3319 S. 11th St. St. ..... Ward)

2. FULL NAME William J. Greene

(a) Residence. No. 3319 S. 11th St. St., 26 Ward.
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Mary Greene

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 7 1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	70	7	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Business
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Canada
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Moses Greene

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT Mary Greene
(Address) 3319 S. 11th St

15. FILED SEP 26 1927 Max C. Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26th 1927

17. I HEREBY CERTIFY That I attended deceased from Sept 23 1927 to Sept 26 1927, that I last saw him alive on Sept 26 1927, and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
90 Hemiplegia
187

Arteriosclerosis (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Acute Pericarditis

..... (duration) ..... yrs. 5 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) Benj F. Stockwell, M. D
, 19 (Address) 415 Finney Bldg

*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 Ivondale Mo. — DATE OF BURIAL Sept 27 1927

20. UNDERTAKER J. J. Quinn — ADDRESS 1533 N. Grand Blvd

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.

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