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

Do not use this space.
15127
~~14860~~

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St Louis (No. 1829 Hickory St. ..... Ward)

File No. .....
Registered No. 4050

2. FULL NAME Bernice Green.

(a) Residence. No. 1829 Hickory St., 22 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: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Emmett Green.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 3 - 1888.

7. AGE: Years 40 | Months 3 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Frankfort Mo.

PARENTS
10. NAME OF FATHER: Richard Miller.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Whitehall Ills.
12. MAIDEN NAME OF MOTHER: Jurella Foster
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: Emmett Green.
(Address) 1829 Hickory St.

15. FILED APR 13 1923, 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April, 12, 1926

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1926, to April 12, 1928 that I last saw her alive on April, 12, 1928, and that death occurred, on the date stated above, at 7:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Pulmonary Tuberculosis
21 23 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Hannibal, Mo.
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Sputum & Xray
(Signed) C. L. Wayman, M.D.
, 19 (Address) 2300 S. Grand Blvd

*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: Hannibal. Mo.
DATE OF BURIAL: Apr 14 1928

20. UNDERTAKER: A. W. McLaughlin 1631
ADDRESS: Mo. Ave.

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.