

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

Do not use this space.

43074

**1. PLACE OF DEATH**

County.....  
Towship.....  
City..... (No.)

Registration District No. **791**  
**1003**  
Primary Registration District No. ....

File No. ....  
Registered No. **12362**  
St. .... Ward)

**2. FULL NAME**

*James Green*  
(a) Residence No. *409 Monroe* St. *16* 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 *Male* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Modie Green*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*abt. 34*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Labourer*  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Miss.*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Modie Green*  
(Address) *409 Monroe*

15. FILED *10 1928* *Max C. Standart* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-16-1928*

17. I HEREBY CERTIFY That I attended deceased from *Dec 14*, 19*28*, to *Dec 16*, 19*28* that I last saw him alive on *Dec 14*, 19*28*, and that death occurred, on the date stated above at *5:30 p.m.*

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

*Pulmonary Tuberculosis*  
*2900*

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS? WAS THERE AN AUTOPSY? *no*

(Signed) *Dr. Edward Bell*, M. D.

*12-18-1928* (Address) *12<sup>th</sup> South Ewing, Ave.*

\*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 *Washington Park* DATE OF BURIAL *Dec 23 1928*

20. UNDERTAKER *Perment - son* ADDRESS *2700 Wash at*

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.

