

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

Do not use this space.

1. PLACE OF DEATH

County.....*A.*..... Registration District No. *791*
 Township.....*St. Louis No.*..... Primary Registration District No. *1003*
 City.....*St. Louis Mo.* (No. *Barnes Loop*).....

File No. *43271*
 Registered No. *12578*
 St. Ward)

2. FULL NAME

Greensie Orlando, Augustus
 (a) Residence. No. *2 1/2 St.* St. *120* Ward. *Hope Ark*
 (Usual place of abode) *Hope, Ark.* (If nonresident give city or town and State)
 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 *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Single*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 20 - 1899*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
29 | *2* | *3*

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Surgeon*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Self oil Co*
 (c) Name of employer *Hope Ark.*

9. BIRTHPLACE (CITY OR TOWN) *Hope*
 (STATE OR COUNTRY) *Ark.*

10. NAME OF FATHER *E. S. Greening*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Camden*
 (STATE OR COUNTRY) *Ark.*
 12. MAIDEN NAME OF MOTHER *Alice McRee*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Wt. Hollie*
 (STATE OR COUNTRY) *Ark.*

14. INFORMANT *R. H. Greening*
 (Address) *Hope Ark.*

15. FILED *24 1928*
Ray C. Standley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 23 1928*
 17. I HEREBY CERTIFY, That I attended deceased from *12-22*, 19*28*, to *12-23*, 19*28*
 that I last saw *h. i. a.* alive on *12-23*, 19*28* and that death occurred, on the date stated above, at *10:33 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
78 Meningitis Acute, Simple
79A Brain abscess non tubercular
non-traumatic cause unknown
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *12/22/28*
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *R. M. Klemme* M. D.
 19 (Address) *579 University Club 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 *Hope Ark* DATE OF BURIAL *12-23-1928*

20. UNDERTAKER *Hope Fun & Und Co.* ADDRESS *Hope Ark.*

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.

