

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

Do not use this space.

29998

1. PLACE OF DEATH

County..... Registration District No. *78*
Township..... Primary Registration District No. *10*
City *St Louis* (No Enroute to City Health # *2* St. Ward)

File No.
Registered No. **8221**

2. FULL NAME

Irene Green
(a) Residence. No. *2322 Pine* St., *21* 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 *Colad* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 23 1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 2 12

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER *James Berry*

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

12. MAIDEN NAME OF MOTHER *Iida Cornelius*

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

14. INFORMANT *Cleo Hellen Allen*
(Address) *2522 Pine St*

15. FILED *UG* *1922* *May C. Barker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 4 - 1929*

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at *2:20 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries, Ruptured Heart, Liver & Lungs, crushed by automobile due to collision with building, St. Louis, Mo. accident.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? *yes* *20*

WHAT TEST CONFIRMED DIAGNOSIS *Dr. P. Herley*
(Signed).....

*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 *Greenwood Cemetery* DATE OF BURIAL *Aug 11 1929*

20. UNDERTAKER *A. F. Walton* ADDRESS *2708 Standard*

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.

ISSUING THIS IS A PERMANENT RECORD

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