

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

1008

Township.....

Primary Registration District No.

City **St. Louis** (No. **319**)

File No. **26364**

7506

Registered No.

St. Ward)

2. FULL NAME

(a) Residence. No. **6660 Washington** St. **D.5** Ward. **St. Louis Co. Mo**

(Usual place of abode)

Length of residence in city or town where death occurred

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)

married

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

Rose Brave Green

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

abt 64 **unknown**

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Tailor

(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)

Russia

10. NAME OF FATHER

Jacob Green

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Russia

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Russia

14. INFORMANT

(Address)

Herman L. Green 1621 400 Goodstedtown

15. JUL - 4 1931

W. C. Starnes

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July 2 1931

17. **No physician attended**
I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., and that death occurred, on the date stated above, at **5408** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxiation due to food poisoning kept administered

CONTRIBUTORY (SECONDARY)

suicide (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?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **J. M. Kerner** M.D.
713, 19 **51** (Address) **Dup. Crown**

*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

DATE OF BURIAL

Mt. Olive Neb **8/5 1931**

20. UNDERTAKER

ADDRESS

H. B. Berger **4712 McPherson**

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.

