

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

Do not use this space.

18446

1. PLACE OF DEATH

County..... Registration District No. **701**
 Township..... Primary Registration District No. **003**
 City St. Louis (No. **ISOLATION HOSPITAL**) St. Ward)

File No.....
 Registered No. **4702**

2. FULL NAME John Green

(a) Residence, No. 3936 Finney St., 11 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 11 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) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1, 1919
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
14 4 23

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Brownsville (STATE OR COUNTRY) Tenn.

13. NAME Ben Green

14. BIRTHPLACE (CITY OR TOWN) Brownsville (STATE OR COUNTRY) Tenn.

15. MAIDEN NAME Lucille Johnson

16. BIRTHPLACE (CITY OR TOWN) Brownsville (STATE OR COUNTRY) Tenn.

17. INFORMANT Leonard Burnside (ADDRESS) Isolation Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE 5/29

19. UNDERTAKER Mamie Undertaking Co. (ADDRESS) 4059

20. FILED 14 19 1933 Registrar. J. J. Bredeck

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24, 1933

22. I HEREBY CERTIFY, that I attended deceased from May 23, 1933 to May 24, 1933

I last saw him alive on May 24, 1933 Death is said to have occurred on the date stated above, at 7:00 p.m.

The principal cause of death and related causes of importance were as follows:

Meningitis, simple Date of onset 5-22
State Med. Certificate 4-22

Other contributory causes of importance 1070

Name of operation Broncho-pneumonia 5-24

Name of operation Mitrallectomy Date of 5-23

What test confirmed diagnosis? Clinical Was there an autopsy? yes

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury....., 19.....

Where did injury occur? No (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify.....

(Signed) John Schaubrunner M. D. (Address) ISOLATION HOSPITAL

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.

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