

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis, Missouri
Township Carroll
City Jefferson Barracks, Missouri, Veterans Administration Facility

Registration District No. 1128
Primary Registration District No. 102480

File No. 22741
Registered No. 219 Ward)

2. FULL NAME GREER, Irl R.

(a) Residence, No. Bunker Hill, Illinois St. Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred Unkn mos. OWN da. How long in U. S., if of foreign birth? - yrs. - mos. - da.

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 Mrs. Rika Greer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 18 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 3 6

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
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) Unavailable 11. Total time (years) spent in this occupation Unav.

12. BIRTHPLACE (CITY OR TOWN) Equality, Illinois
(STATE OR COUNTRY)

13. NAME Unavailable

14. BIRTHPLACE (CITY OR TOWN) Unavailable
(STATE OR COUNTRY)

15. MAIDEN NAME Martha ?

16. BIRTHPLACE (CITY OR TOWN) Unavailable
(STATE OR COUNTRY)

17. INFORMANT C. H. SMITH, M.D., Clinical Director
(ADDRESS) Vet. Adm. Facility, Jeff. Brks., Mo.

18. BURIAL, CREMATION OR REMOVAL PLACE Bunker Hill DATE June 27, 1934

19. UNDERTAKER Mullen Bros
(ADDRESS) 425 9th St. St. Louis

20. FILED June 25, 1934 D. F. Tate M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24, 1934 1934

22. I HEREBY CERTIFY, That I attended deceased from June 22, 1934 to June 24, 1934

I last saw him alive on June 24, 1934. Death is said

to have occurred on the date stated above, at 4:10 P.M.

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

Brain Abscess

Extra dural abscess

Other contributory causes of importance:
Otitis Media, chronic
Mastoiditis, chronic

Mastoid operation with decompressions

Name of operation Spinal Punctures Date of 6/26/34
What test confirmed diagnosis? Spinal Was there an autopsy? Yes
Fluid Exam, Lab. and Neurological findings.

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (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) H. C. G. S. M.D., M. D.

(Address) Vet. Adm. Facility, Jeff. Brks., Mo.

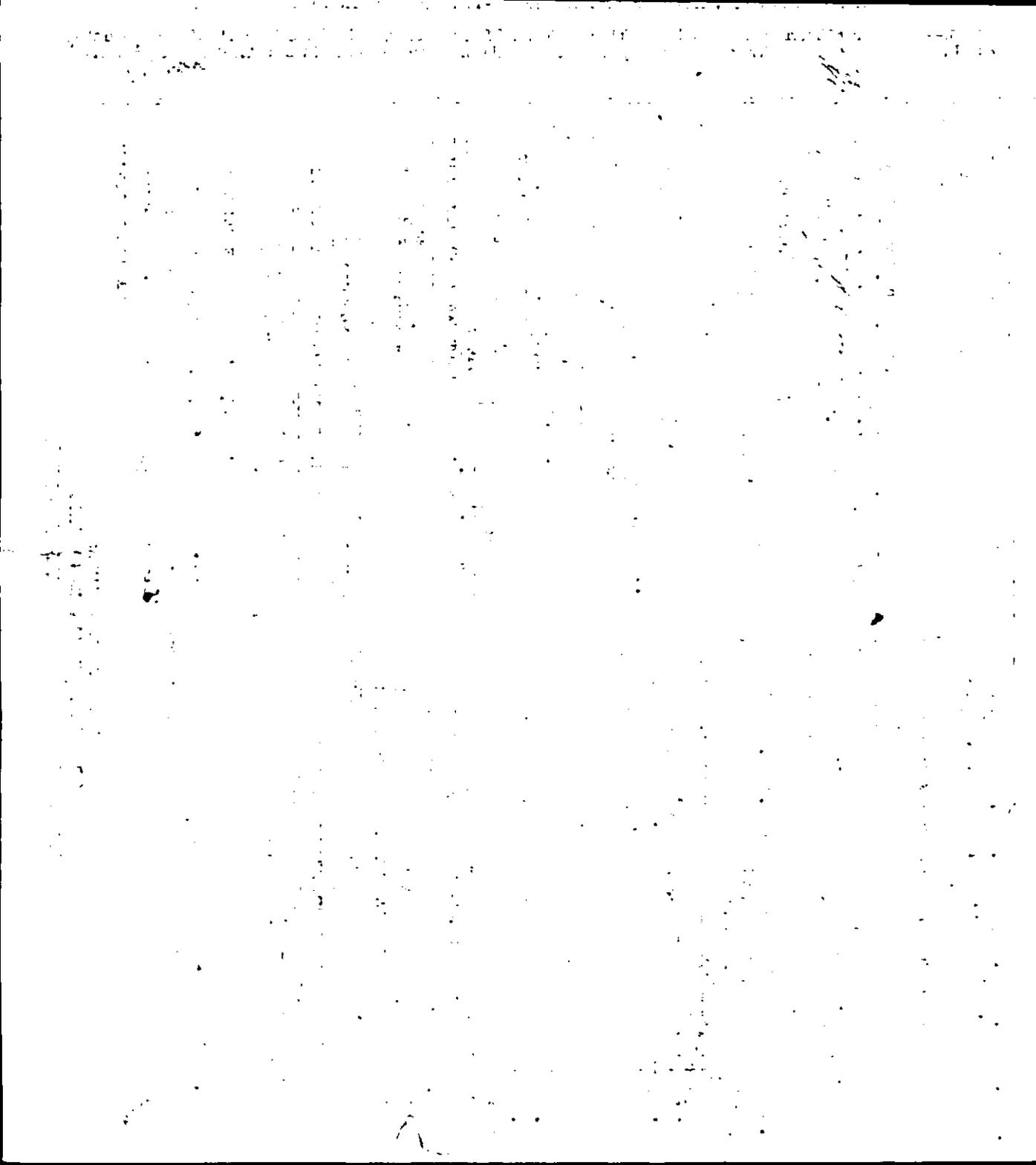
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

JUL 21 1934

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St Louis Co

WASHINGTON

22741

219

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Dr R Green*
Who died at *Sts Adm Inc* on *June 24 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: _____ Years _____ Months _____ Days _____
Sex *M* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *41* Months *3* Days *6*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Brain abscess extra dural abscess
Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____
Birthplace of father (State or country) *Streptococci Infection*
Birthplace of mother (State or country) *Confirmed by laboratory test*
Principal cause of death: _____

Otitis media chr - mastoiditis chr
Other contributory causes of importance _____

Name of operation _____ Date of _____ *99a*
What test confirmed diagnosis? *Labs* Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

Name of physician *W C Gibson*
Address of physician *Sts Adm Inc. Jeff Bks mo*

Signature of Registrar *B G Gate MD* Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. *1123*

Primary Reg. Dist. No. *4248 B*

E. T. McLaugh
Special Agent Registrar