AUG 30 1937

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

Do not use this space.

1. PLACE OF DEATH
County St. Louis — Registration District No. 790 — File No. 28337
Township ~~Clayton~~ — Primary Registration District No. 6032c — Registered No. 229
City Clayton (No. St. Ward)

2. FULL NAME Stella Green
(a) Residence, No. 113 W. Etta, Luxembourg St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 1½ 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: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: widow
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 29, 1897
7. AGE: 40 YEARS — MONTHS: 3 — DAYS: 5 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. nil
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) (STATE OR COUNTRY) St. Louis, Mo.

FATHER
13. NAME Wm. Grover
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
15. MAIDEN NAME Margaret Farmer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

17. INFORMANT (ADDRESS) Mr. Kaier, welfare worker
18. BURIAL, CREMATION, OR REMOVAL PLACE Fayetteville Ark DATE 7/6, 1937
19. UNDERTAKER (ADDRESS) C. Hoffmeister 7814 So Bdway
20. FILED 7/6, 1937 Dr A J Squarelli Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-4-37, 19

22. I HEREBY CERTIFY, That I attended deceased from 3-10-37, 19, to 7-4-37, 19
I last saw her alive on July 4, 1937. Death is said to have occurred on the date stated above, at 8:50 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
unknown	
Chronic Myocarditis, auricular Fibrillation.	

Other contributory causes of importance:
none

93c

Name of operation ..... Date of .....
What test confirmed diagnosis? clinical Was there an autopsy? no

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) A W Hauss M. D.
(Address) St. Louis County 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.