

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

32786
Do not use this space.

1. PLACE OF DEATH **Homer G Phillips Hospital**

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **2601** N. Whittier St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **18** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Levi Green**

(a) Residence, No. **2915 Franklin** St. **21** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **C** 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) **June 24, 1898**

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
39	2	24	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Laborer**

9. Industry or business in which work was done, as saw mill, bank, etc. **common**

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) **Illinois**

FATHER

13. NAME **Felix Green**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Maryland**

MOTHER

15. MAIDEN NAME **Maggie Chase**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 18** 19 **37**

22. I HEREBY CERTIFY, That I attended deceased from **Aug. 27**, 19 **37**, to **Sept. 18**, 19 **37**
 I last saw him alive on **Sept. 18**, 19 **37**. Death is said to have occurred on the date stated above, at **1:15** m. **p.m.**
 The principal cause of death and related causes of importance were as follows:

Brain tumor Benign

Date of onset **8/27/37**

Other contributory causes of importance: *JH*

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. L. Lewis*, M. D.
 (Address) **2601 N Whittier**

17. INFORMANT **Evelyn Hilliard**
 (ADDRESS) **2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL **Edwardsville, Ill** DATE **9/23** 19 **37**

19. FUNERAL DIRECTOR **W.M.C. McDowell**
 (ADDRESS) **3526 Franklin Ave**

20. FILED **J. Brebeck** 19 **37**
 Local Registrar.

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.

3/1-2222430

OCT 14 1937

SEP 23 1937

STATEMENT BY LICENSED EMBALMER

I, William C. McDowell Licensed Embalmer No. 2114

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____ Registered Apprentice No. _____
working under my personal supervision.

Signed William C. McDowell
Licensed Embalmer No. 2114

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)