

FEB 12 1938

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

218
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **City Hospital #1** Registered No. **74**
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Thomas W. Greene 650**

(a) Residence, No. **Forder Rd., Mehlville, Mo.** St. **NR** (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 **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Divorced**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 6, 1872**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 4 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Engineers**
 9. Industry or business in which work was done, as saw mill, bank, etc. **retired**
 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 **Greene**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER 15. MAIDEN NAME **Unknown**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT (ADDRESS) **Dr. M.L. Greene Mehlville, Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New St. John's** DATE **Jan 3, 1938**

19. FUNERAL DIRECTOR (ADDRESS) **Fendler Undertaking Co. 744 Lemay Ferry Road**

20. **JAN 3 1938** Local Registrar. **J.P. Bredbeck**

MEDICAL CERTIFICATE OF DEATH
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 2, 1938**
 22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at **3:00 A.M.**
 The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexy
Arteriosclerosis
 Date of onset
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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? **No**
 If so, specify.....
 (Signed) **Joseph M. Johnson** M.D.
 (Address) **Deputy Coroner**

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.

APPROVED

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STATEMENT BY LICENSED EMBALMER

I, Harry Schumacher, Licensed Embalmer No. 2679

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 Harry J Schumacher
Licensed Embalmer No. 2679

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.)