

FILED FEB 17 1940

Registration District No. 1000 Primary Registration District No. \_\_\_\_\_ Registrar's No. 333

1. PLACE OF DEATH: 3  
(a) County \_\_\_\_\_  
(b) City or town St. Louis Mo.  
(c) Name of hospital or institution: St. Louis Mo. 22  
(d) Length of stay: \_\_\_\_\_  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis Mo.  
(d) Street No. 1116 A. So. Compton Ave.  
(e) Foreign born years \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas Anthony Green 650  
3. (b) If veteran, name war No. Veteran 3. (c) Social Security No. none  
4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Vilola May Green. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 24, 1873

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_ year 1940 hour \_\_\_\_\_ minute 5 P. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
66 0 12

Immediate cause of death Progressive Myocarditis  
Atherosclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace New Madrid Mo.  
10. Usual occupation Nil

Other conditions 930  
(Include pregnancy within 3 months of death)

11. Industry or business none  
12. Name John Green  
13. Birthplace Unknown  
14. Maiden name Mary F. Waller  
15. Birthplace Unknown

Major findings: 930  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant's own signature Ionia Wallace  
(b) Address 1116 A. So. Compton Ave.  
17. (a) \_\_\_\_\_ (b) Date thereof 1/12/40.  
(c) Place: burial or cremation Washington Park Cem.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director Wright's Funeral Home  
(b) Address 3100 Easton Ave  
19. (a) JAN 12 1940 (b) \_\_\_\_\_

23. Signature Joseph M. Green  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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.

PHYSICIAN  
Underline the cause to which death should be charged statistically

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*William C. McDowell*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

*William C. McDowell*

Licensed Embalmer No.....

*2114*

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**