DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30845

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 8122

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2818 La Salle (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) Forty yrs

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 22

(c) City or town St Louis (If outside city or town limits, write "RURAL")

(d) Street No. 2818 Lasalle (If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME ESTHER GREEN

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex female

5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Daniel W Green

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased June (Month) 25 (Day) 1878 (Year)

8. AGE: Years 62 Months 3 Days 2 If less than one day hr. min.

9. Birthplace La (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Cass Landers

13. Birthplace La (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Queen Landers

15. Birthplace La (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Daniel W Green

(b) Address 2818 Lasalle

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-40 (Month) (Day) (Year)

(c) Place: burial or cremation St Peters cemet

18. (a) Signature of funeral director J Burger

(b) Address 2769 Allenteau

19. (a) SEP 30 1940 (Date received local registrar) (b) J F Bauduck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27 year 1940 hour 9 minute 30 P M.

21. I hereby certify that I attended the deceased from 1-8-40, 19..., to 9-27, 19 40 that I last saw her alive on 9-27, 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral coma & hemiplegia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature P V Guyer (M. D. or other)

Address 2767 Park Date signed 9-30-40

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.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed. S. J. Watson

Licensed Embalmer No. 269 f

P. O. Address 2769 Thornton

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

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