

Registration District No. _____

Primary Registration District No. _____

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 Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 night
(Specify whether _____)
In this community Life
years, months or days

3. (a) PRINT FULL NAME Ruth Ann Green

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fem 5. Color or race Col. 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 28, 1937
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 1 18 hr. min.

9. Birthplace St. Louis - Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Sam Saunders

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

14. Maiden name Father Willard

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

16. (a) Informant Esther Green

(b) Address 634 Athlone Ave.

17. (a) Burial (b) Date thereof 10/21/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Arthur Green

(b) Address 3517 So. Lech Ave

19. (a) OCT 19 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 634 Athlone Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16th
year 1940 hour 8:45 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis following Ruptured Appendix

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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 plane) _____
While at work? _____
Means of injury _____
23. Signature Arthur Green (M. D. or other)
Address _____ Date signed 10/18/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 16 1940

791

1003

9

0

0

0

0

0

0

0

0

Duration

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.....

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

working under my personal supervision.

Signed

W. M. Green

Licensed Embalmer No. 1173

P. O. Address 3517 Saalder

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

If this body is not embalmed, fact should be so stated above.