

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

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.

FILED JUN 29 1942

Registration District No. 24

Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Lemuel Green

3. (b) If veteran, name war _____

3. (c) Social Security No. NONE

4. Sex Male 5. Color or race colored

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

6. (b) Name of husband or wife Maggie Green

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased 8 18 1908
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

33	10	3	hr. min.
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9. Birthplace Keatree, Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name John Green

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

14. Maiden name Sophonria Hammerton

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

16. (a) Informant's own signature St. Louis Co. Hospital

(b) Address Clayton Mo

17. (a) Burial (b) Date thereof 6/25/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Peterson Cem. Clayton Mo

18. (a) Signature of funeral director Charles Deas

(b) Address 4107 Finney Ave

19. (a) JUN 24 1942 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")

(d) Street No. 917 Truesdale
(If rural, give location)

(e) If foreign born, how long in U. S. A? no years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 21
year 1942 hour 10:45AM minute _____ M.

21. I hereby certify that I attended the deceased from 6-19-42
19____, to 6-21-42, 19____;
that I last saw him alive on 6-21-42, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death peripheral vascular collapse

Duration hrs?

Due to generalized peritonitis 5 days

Due to ruptured appendix 5 days

Other conditions (include pregnancy within 3 months of death) 12 1 1

Major findings: generalized peritonitis & abscess in appendix fossa

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Joseph D. Judy (M. D. or other) NO

Address St. Louis County Hospital signed 6-23-

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 James A. Johnson, Registered Apprentice No. _____ working under my personal supervision.

Signed

James A. Johnson
Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22256
Registrar's No. 1360

Registration District No. 784

Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County St Louis Clayton
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Louis Co. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Lemuel Green

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Maggie 6. (c) Age of husband or wife if alive 18 years
7. Birth date of deceased Aug 18 1908
(Month) (Day) (Year)

8. AGE: Years 33 Months 10 Days 3 (If less than one day min.)

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

10. Usual occupation.....

11. Industry of business.....

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

14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a)..... (b) H. M. Green M.D.
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month..... Day.....
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... live on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other).....
Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

S-22256

Curry