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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

JUL 3 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5778

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 Stoddard Street /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life years, months or days

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. 2818 Stoddard Street
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Green

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

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

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

7. Birth date of deceased May 3, 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 1 15 hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Adam Green
13. Birthplace Evergreen Alabama
(City, town, or county) (State or foreign country)
14. Maiden name Celia Spears
15. Birthplace Florence Alabama
(City, town, or county) (State or foreign country)

16. (a) Informant Rosa Gaines
(b) Address 1423 Trendley Ave., E. St. Louis,

17. (a) Removal (b) Date thereof 6/25/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation E. St. Louis Ill

18. (a) Signature of funeral director R. M. C. Green

(b) Address 3517 Laclode Avenue

19. (a) JUN 24 1943 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1943 hour 1 minute 15 A.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.

Immediate cause of death
Carcinoma of Prostate
Glands
Due to Abscess of Left Testis
Due to _____

Other conditions (Include pregnancy within 3 months of death) 51

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?

While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature William G. Perry (M. D. or other) _____
Address St. Louis Date signed 7/22/43

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

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



Licensed Embalmer No.

1173

P. O. Address

3517 Soledad Av

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, fact should be so stated above.