

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 26683

Registration District No. 318

Primary Registration District No.

Registrar's No. 7503

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. 3 Hrs. 22 Min  
(Specify whether  
In this community..... (Yes or No)  
years, months or days)

3. (a) PRINT FULL NAME Greenwood

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased. 7 19 43  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 hr. 22 min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name. Hazel Greenwood

15. Birthplace. West Point Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant M. Sherard, R.R.

(b) Address. 2601 N. Whittier Street

17. (a) Burial (b) Date thereof. AUG 26 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. CITY CEMETERY

18. (a) Signature of funeral director H. Merschman

(b) Address City of St. Louis

19. (a) AUG 25 1943 (b) J. F. Brebeck  
(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. 4165 Fairfax Ave.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19  
year 43 hour 7 minute 22 am.

21. I hereby certify that I attended the deceased from 7-19 1943, to 7-19 1943  
that I last saw him alive on 7-19 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death. Prematurity

Due to Unknown

Due to Unknown

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature. W. S. Smiley (M. D. or other).....

Address 2601 N. Whittier St. Date signed.....

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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.....

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, fact should be so stated above.**