

No. 2  
-2-43  
17-39  
X39597

FILED APR 13 1944

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. 3248

1. PLACE OF DEATH: **318**

(a) County ST. LOUIS

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

(c) Name of hospital or institution: GOOD SAMARITAN HOME 54500 WASHINGTON BLVD  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 YRS.  
(Specify whether in this community years, months or days) 27 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 17

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL") 712

(d) Street No. 4500 WASHINGTON BLVD.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FLORA GREENWOOD

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 5<sup>th</sup> year 1944 hour 12:15 minute A. M.

21. I hereby certify that I attended the deceased from Feb 15 1944 to April 5 1944 that I last saw her alive on April 4 1944 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife WALTER GREENWOOD 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DECEMBER 23 1867  
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death arteriosclerosis

Due to \_\_\_\_\_

Due to 59

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

9. Birthplace ST. MARY'S OHIO  
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name H. A. HOPSON

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

14. Maiden name FRANCES SEAMAN

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

16. (a) Informant Rev. J. H. Overbeck

(b) Address 4500 Washington Blvd

17. (a) REMOVAL (b) Date thereof APR 6 - 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. MARY'S, OHIO

18. (a) Signature of funeral director Calvin J. Bantz Funeral Home

(b) Address 4828 Natural Bridge Blvd.

19. (a) Date received local registrar APR 6 1944 (b) J. F. Bereman  
(Registrar's signature)

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 J. F. Bereman (M. D. or other) M.D.  
Address 3720 Washington Date signed 4/12/44

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.....

*John Mlinar*

Licensed Embalmer No. *4186*

P. O. Address.....

*St. Louis Mo.*

**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.**