

FILED JUL 1 1944

Registration District No. 377

Primary Registration District No. 6076

State File No. _____

Registrar's No. 1347

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Koch

(c) Name of hospital or institution Koch Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 mths 28 dgs
In this community 34 yrs 10 mths 28 dgs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 002

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1113 N. Channing 9
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Joshua Green

3. (b) If veteran, name war _____

3. (c) Social Security No. 499-01-2808

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1944 hour 12 minute 50 P M.

21. I hereby certify that I attended the deceased from July
20 1943, to JUNE 11 1944
that I last saw h. im alive on JUNE 17 - 1944
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro

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

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

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

7. Birth date of deceased: April (Month) 5 (Day) 1890 (Year)

Immediate cause of death _____

Pulmonary Tuberculosis 16 mths

Due to _____

Due to _____

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

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>2</u>	<u>12</u>	hr. _____ min.

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

10. Usual occupation Laborer

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Coleman Green

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

14. Maiden name May Annette

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

16. (a) Informant Hospital Record

(b) Address Koch P.O. Koch MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-44 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. R. Randle & Son

(b) Address 3133 Bell Ave

19. (a) JUN 23 1944 (b) E. J. McDevien, MD (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? _____

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

23. Signature A. A. Souner (M.D. or other) _____
Address Koch Hosp. Koch MO Date signed 6-17-44

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

JAN 23 1946

JAN 23 1946

JAN 25 1946

AUG 3 1944

25 1946

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 *S. J. Watson*

Licensed Embalmer No. *2498*

P. O. Address *2769 Chautauque*

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.