

FILED NOV 1 1948  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

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

23  
000  
17  
9

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town St Louis, Mo.

(c) Name of hospital or institution:  
In route to hospital 3  
(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 Illinois (b) County St. Clair

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

(d) Street No. 1937 Trendley  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country 2

3. (a) PRINT FULL NAME Edgar Green

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20th  
year 1944 hour 8 minute 35 AM

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Col.

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ days

7. Birth date of deceased: Feb 15 1935  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Tuberculous  
Pulmonary Adenitis

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

9	8	5	_____ hr. _____ min.
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9. Birthplace Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation School

PHYSICIAN \_\_\_\_\_

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

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

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER {

12. Name Ernest Green

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

14. Maiden name Viola Riser  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Viola Green

(b) Address 1937 Trendley

17. (a) E. St. Louis (b) Date thereof 10/23/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Porter Methodist

18. (a) Signature of funeral director W.M. Green

(b) Address 3517 Laclade Ave

19. (a) OCT 21 1944 (b) J.F. Bredeck  
(Date received by registrar) (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 Thomas F. Callan (M, D or other) \_\_\_\_\_  
Address Deputy Coroner Date 10-21-44

**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 *W. M. Green*.....

Licensed Embalmer No. *1173*.....

P. O. Address *3517 Laclade 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, fact should be so stated above.**