

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 2106

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one day
(Specify whether years, months or days)

In this community seven years

3. (a) PRINT FULL NAME Patsy Green

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race Col

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

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

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased 6 (Month) 1 (Day) 1898 (Year)

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

46 4 11 hr. min.

9. Birthplace Harston Miss
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

MOTHER FATHER

12. Name Carroll Thompson

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

14. Maiden name Sarah Carter

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

16. (a) Informant self

(b) Address 61 St. Minerva

17. (a) Burial (b) Date thereof 10-17-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director H. F. Walton

(b) Address 2707 Stoddard St

19. (a) OCT 17 1944 (b) E. J. McLaughlin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis

(c) City or town Weller 96
(If outside city or town limits, write "RURAL")

(d) Street No. 6154 Minerva
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 year 1944 hour 11 minute PM M.

21. I hereby certify that I attended the deceased from Oct 10, 1944, to 10-11, 1944

that I last saw h. alive on Oct 11, 1944

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
in choroid

Duration _____

Due to Hypertensive cerebral vascular disease

Due to 932

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

Major findings: _____

Of operations _____

Of autopsy _____

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)

(e) Means of injury 2

23. Signature H. M. M. D. (M. D. or other) _____

Address 601 Brentwood Circle Date signed 10/17/44

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~~ Chester A. Marshall, Registered Apprentice No. _____ working under my personal supervision.

Signed Chester A. Marshall

Licensed Embalmer No. 4381

P. O. Address 4902 Finney

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.