V. S. No. 2
100M—5-43
Rev. 5-17-39
Form I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1946 MAR 31 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7480

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 1721

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

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: _____ (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: 5 days (Specify whether years, months or days) In this community: 25 yrs

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.: 4124 Page Aveer (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME: Bertha Mitchell Green

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: FEMALE

5. Color or race: Negro

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

6. (b) Name of husband or wife: Lewis GREEN

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

7. Birth date of deceased: 3 (Month) 1 (Day) 1892 (Year)

8. AGE: Years 53 Months 11 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace: CARROLLVILLE (City, town, or county) ILL (State or foreign country)

10. Usual occupation: FORME OWNER - Filling Station

11. Industry or business: Shell SERVICE Station

FATHER 12. Name: John WILLIAMS

FATHER 13. Birthplace: ? (City, town, or county) ILL (State or foreign country)

MOTHER 14. Maiden name: EMANDA ALLEN

MOTHER 15. Birthplace: ? (City, town, or county) ILL (State or foreign country)

16. (a) Informant: SIGNA Ruffins

(b) Address: 4124 Page AVE.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 2-23-46 (Month) (Day) (Year)

(c) Place: burial or cremation: Washington PARK

18. (a) Signature of funeral director: Mary Hale

(b) Address: 4202 E. Finney AVE.

19. (a) FEB 20 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 18 year 1946 hour 1 minute 5 A M.

21. I hereby certify that I attended the deceased from 2-13, 1946 to 2-18, 1946; that I last saw her alive on 2-18, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Accident — Duration: Unk

Due to: _____

Due to: _____

Other conditions: Unknown (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy: No

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature: O. J. Ayer (M. D. or other)

Address: 2601 N Whittier Date signed: 2/18/46

(Licensed Embalmer's Statement on Reverse Side)

46-4074

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, [redacted]

, Registered Apprentice No.

working under my personal supervision.

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.