

FILED APR 5 1946

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2926**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Booth Memorial Hospital
(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 Minnesota (b) County Hennepin 991
(c) City or town Minneapolis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2400 West Calhoun 0
(If rural, give location) NR. 2
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Baby Green

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased: 3 - 9 - 46
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 16 hr. 45 min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name John Allen Green
13. Birthplace Minneapolis, Minnesota
(City, town, or county) (State or foreign country)
14. Maiden name Paul Patricia Williams
15. Birthplace Minneapolis, Minnesota
(City, town, or county) (State or foreign country)

16. (a) Informant John Allen Green

(b) Address 2400 W. Calhoun - Minneapolis, Minn

17. (a) Anatomical Board (b) Date thereof MAR 28 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutger St

19. (a) MAR 28 1946 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th
year 1946 hour 11 minute 30 A.

21. I hereby certify that I attended the deceased from 3/9, 1946, to 3/10, 1946.
that I last saw h.i.m. alive on Sunday 3/10, 1946.
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Infant
5 mo.

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 (a) about home, on farm, in industrial place, in public place? _____

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

23. Signature Alvin Foster (M. D. or other) _____

Address 727 Mrs. Thelma Bly Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
10084

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.....

Licensed Embalmer No.....

P. O. Address.....

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.