DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 23 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42431

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10877

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: The Peoples Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 4217 West Belle
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Infant Green

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased November 23, 1946
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
--	--	1	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name James Haywood Green
13. Birthplace Baxter, Arkansas (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name William Malone
15. Birthplace Fulton, Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant The Peoples Hospital
(b) Address 2221 Locust St.

17. (a) ~~Removal~~ Burial (Burial, cremation, or removal) (b) Date thereof 11/26/46 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept

19. (a) 12-7-46 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 23rd year 1946 hour 1:00 minute P M.

21. I hereby certify that I attended the deceased from 11:00 a.m. 11/23/46, 1946, to 11/23/46, 1946, that I last saw him alive on 11/23/46, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Asphyxiation	
Due to: Arrested shoulder on symphysis	
Due to:	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. ~~or other~~)

Address 3146 Nachelle Date signed 11/26/46

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.