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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 9 1947

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

Primary Registration District No.

State File No. 15126

Registrar's No. 1325

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 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State MISSOURI (b) County

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")

(d) Street No. 2826 GAMBLE ST. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ELLA GREEN

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex FEMALE

5. Color or race COL

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

6. (b) Name of husband or wife WILLIAM GREEN

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

7. Birth date of deceased OCT (Month) 27 (Day) 1885 (Year)

8. AGE: Years 61 Months 5 Days 29 If less than one day hr. min.

9. Birthplace PIERCE CITY (City, town, or county) MO (State or foreign country)

10. Usual occupation DOMESTIC

11. Industry or business

FATHER

12. Name JAUSHA WALKER

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

MOTHER

14. Maiden name HELEN THOMAS

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

16. (a) Informant William Green

(b) Address 2826 Gamble St

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-30-47 (Month) (Day) (Year)

(c) Place: burial or cremation Bellerive Cem

18. (a) Signature of funeral director A. J. (Buddie) Walton

(b) Address 2707 Stoddard St

19. (a) APR 28 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 26 year 1947 hour 5 minute 30 P.M.

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.

Duration

Immediate cause of death Chronic Interstitial

Due to (Poly Cystic) Nephritis

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 (M. D. or other)

Address Date signed 4/28/47

(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.

Emb. cert. filed separately

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.