

10096

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2931

FILED APR 15 1949

318

1003

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital				d. STREET ADDRESS (If rural, give location) 4037 West Pine			
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) Westley		c. (Last) Green	
4. DATE OF DEATH		(Month) (Day) (Year)		March 30, 1949			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 5, 1917		9. AGE (In years last birthday) 31	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Technician		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Westley J. Green		13b. MOTHER'S MAIDEN NAME Cecelia Schaefer		14. NAME OF HUSBAND OR WIFE Zita Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Zita Green, 4037 West Pine		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Coronary Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH abt 5 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE, (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 24, 1949, to Mar 30, 1949, that I last saw the deceased alive on Mar 30, 1949, and that death occurred at 7:50 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Sun P. Sean				(Degree or title) M.D.		23b. ADDRESS 3720 Washington St. St. Louis, Mo.	
23c. DATE SIGNED 3/30/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/2/49		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri		DATE REC'D BY, LOCAL REG. MAR 31 1949		REGISTRAR'S SIGNATURE J. B. Lacater		25. FUNERAL DIRECTOR'S SIGNATURE PROVOST UND. CO., 3710 N. Grand Blvd.	

(Licensed Embalmer's Statement on Reverse Side)

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

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[Handwritten signature]

[Handwritten mark]

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Albert Hayfield

Signed _____
Student Embalmer

Licensed Embalmer No. 3070

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.