

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4836

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY ST LOUISIS 91	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUISIS (1)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN OVERLAND 13	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST LUKE'S HOSPITAL		d. STREET ADDRESS (If rural, give location) NR - 9106 DELPHINE 1	

3. NAME OF DECEASED (Type or Print)	a. (First) ORA	b. (Middle) MAY	c. (Last) GREENE	4. DATE OF DEATH (Month) (Day) (Year) JUNE 1 1949
-------------------------------------	-----------------------	------------------------	-------------------------	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 19 1863	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 0 Days 13	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	-------------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) EAST ST LOUISIS ILL	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	---

13a. FATHER'S NAME DAVID L HILL	13b. MOTHER'S MAIDEN NAME WILLIS	14. NAME OF HUSBAND OR WIFE WM WALLACE GREENE
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME William Greene	ADDRESS 9106 Delphine Ave Overland, Mo.
---	----------------------------------	---	--

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		1 week
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive cardiovascular		10 yrs +
	DUE TO (c) Cardiac failure		6d
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal pneumonia		3d.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 93 MO
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H42 X
--	--	---

22. I hereby certify that I attended the deceased from 1936, to June 1, 1949, that I last saw the deceased alive on June 1, 1949, and that death occurred at 10:00a., from the causes and on the date stated above.

23a. SIGNATURE J. B. Lasater (Degree or title) M.D.	23b. ADDRESS 864 Hamilton Blvd St. Louis 12. Mo.	23c. DATE SIGNED 6-2-49
---	---	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 6-3-49	24c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.
---	-------------------------	--	---

DATE REC'D BY LOCAL REG. JUN 3 1949	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE BAUMANN BROTHERS INC.	ADDRESS OVERLAND MO
--	--	---	----------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

HL-1-8-12.71.

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.

Student
Student Embalmer

Signed Oscar J. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 14

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.