

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31802
State File No. 7897
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) OR ST. LOUIS MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4172^a FLAD		d. STREET ADDRESS (If rural, give location) 4172^a FLAD	

3. NAME OF DECEASED (Type or Print)	a. (First) Jesse	b. (Middle) T	c. (Last) GREENE	4. DATE OF DEATH (Month) (Day) (Year) 9-10-49
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG. 11 1887	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months — Days 29	IF UNDER 1 HR. Hours — Min. —
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIGHT WATCHMAN	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME FRANK GREENE	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE CAROLINE GREENE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 493-03-4470	17. INFORMANT'S SIGNATURE OR NAME CAROLINE GREENE	ADDRESS 4172^a FLAD
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		1 Week
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis		2 Months
DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) ST. LOUIS MO
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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? Heart
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22. I hereby certify that I attended the deceased from **Jan. 10, 1949** to **Sept. 10, 1949**, that I last saw the deceased alive on **Sept. 10, 1949**, and that death occurred at **11:45 m.**, from the causes and on the date stated above.

23a. SIGNATURE Louis Bauer M.D.	(Degree or title)	23b. ADDRESS 2676 Gravois Ave.	23c. DATE SIGNED 9/10/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE SEPT. 13, 1949	24c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. SEP 12 1949	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis	ADDRESS 2906 Gravois
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Harmer C Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Grant

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.