

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)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri	
c. LENGTH OF STAY (in this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3708 California		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		d. STREET ADDRESS (If rural, give location) 3708 California	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) William	b. (Middle) G.	c. (Last) Green	(Month) 8	(Day) 30	(Year) 50
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 23, 1892	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME James Green	13b. MOTHER'S MAIDEN NAME Jennie Hall	14. NAME OF HUSBAND OR WIFE Lilian
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) Yes WW #1	16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME Lilian Green--3708 California

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 3 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Arteriosclerosis of Arteries		
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 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? 58 ft. D

22. I hereby certify that I attended the deceased from Aug 29 1950, to Aug 30 1950, that I last saw the deceased alive on Aug 30, 1950, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE E. Kunzle	(Degree or title) M.D.	23b. ADDRESS 2800 N. Olive	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/2/50	24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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DATE REC'D BY LOCAL REG. AUG 31 1950	REGISTRAR'S SIGNATURE J. B. Passtier	25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldner	ADDRESS 3634 Gravois
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 26 1950

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Frank J. Hyland, Jr.

Signed.....
Student Embalmer

Licensed Embalmer No. *2645*

P. O. Address *St. Louis*

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.