

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31673  
State File No. ....

BIRTH NO. 61244-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8008

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 town) St. Louis c. LENGTH OF STAY (in this place) 14 hrs 10 min  
c. CITY (If outside corporate limits, write RURAL and give township) St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips d. STREET ADDRESS (If rural, give location) 3301 Delmar

3. NAME OF DECEASED  
a. (First) Calvin b. (Middle) Green c. (Last) Green 4. DATE OF DEATH (Month) (Day) (Year) 9 11 50

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1 8. DATE OF BIRTH 9-11-50 9. AGE (in years last birthday) 14 IF UNDER 1 YEAR Months 10 IF UNDER 12 HRS. Days 10 Hours 10 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Clemen Green 13b. MOTHER'S MAIDEN NAME Mary Robinson 14. NAME OF HUSBAND OR WIFE

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. 17. INFORMANT'S SIGNATURE OR NAME Maitha M. Sherrard ADDRESS 2601 N. Whittier

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Premature birth  
\*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  
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  
Incomplete Obstruction of Trachea by Mucosity

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES  NO

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) (m.) 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR 776X

22. I hereby certify that I attended the deceased from 9-11-1950, to 9-11-1950, that I last saw the deceased alive on 9-11-1950, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE William L. Sunkler (Degree or title) M. D. 23b. ADDRESS 2601 N. Whittier 23c. DATE SIGNED 9-12-50

24a. BURIAL, CREMATION, REMOVAL (Specify) 10 24b. DATE SEP 21 1950 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board 24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. SEP 21 1950 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc. ADDRESS Manchester Ave. St. Louis 10, Mo.

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

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**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.....

Signed.....  
Student Embalmer

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.