

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **36413**  
 Registrar's No. **9195**

**FILED** OCT 21 1952

**318**

**1003**

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 <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		<b>2129</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>4701 a Vernon</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Enoch</b>		b. (Middle) _____		c. (Last) <b>Green</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 1 1952</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 19, 1896</b>		9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13a. FATHER'S NAME <b>James Moore</b>		13b. MOTHER'S MAIDEN NAME <b>Moren Mitchell</b>		14. NAME OF HUSBAND OR WIFE <b>Octavia</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Octavia Green 4701a Vernon Ave.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b>  ANTECEDENT CAUSES DUE TO (b) <b>Hypertensive Heart Disease</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>  DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <b>Arthracosilicosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
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? <b>443X</b>			
22. I hereby certify that I attended the deceased from <b>9-28</b> , 1952, to <b>10-1</b> , 1952, that I last saw the deceased alive on <b>10-1</b> , 1952, and that death occurred at <b>8:20p m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Charles P. Jards</b>				23b. ADDRESS <b>2601 N Whittier St</b>		23c. DATE SIGNED <b>10-3-52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10-4-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>SHIPPING</b>		24d. LOCATION (City, town, or county) (State) <b>Little Rock Arkansas</b>		
DATE REC'D BY LOCAL REG. <b>OCT 4 1952</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ellis Funeral Home 2820 Stoddard</b>			

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 \_\_\_\_\_

*Gustav E. Culkin*

Licensed Embalmer No. 4198

P. O. Address St Louis 13 Mo

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.