

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **17925**
Registrar's No. **4971**

FILED JUN 12 1956

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4971			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MISSOURI				b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place township) 5 Weeks		c. CITY OR TOWN 4020 Bissell Hills 1		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital (Kingshighway)				e. STREET ADDRESS (If rural, give location) 10216 Cabot Dr.					
3. NAME OF DECEASED (Type or Print) a. (First) MARY			b. (Middle) _____			c. (Last) GREENWAY			
4. DATE OF DEATH (Month) (Day) (Year) May 23-1956			5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		
8. DATE OF BIRTH May 3-1873			9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months Days		IF UNDER 26 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Housework			11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Murphy			13b. MOTHER'S MAIDEN NAME Johanna O'Conner			14. NAME OF HUSBAND OR WIFE Albert Greenway			
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. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. G. D. Meloy			ADDRESS 10216 Cabot Dr.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac DECOMPENSATION ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Secondary Valve Damage Secondary to Chronic Cholelithiasis & Cholecystitis DUE TO (c) Generalized arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dehydration & Acetonuria						INTERVAL BETWEEN ONSET AND DEATH 24 hours. 5 TO 10 yrs 5 TO 10 yrs 2 months.	
19a. DATE OF OPERATION 4/23/56		19b. MAJOR FINDINGS OF OPERATION Cholelithiasis Cholecystitis. Chronic Duodenitis. Striated Intestine.						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) 584x				(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?					
22. I hereby certify that I attended the deceased from 4/7/56 , 19 56 , to 5/23 , 19 56 , that I last saw the deceased alive on 5/23 , 19 56 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.									
23a. SIGNATURE S. J. Cooper M.D.				(Degree or title) M.D.				23b. ADDRESS 1901 Madison St.	
23c. DATE SIGNED 5/23/56		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 25-1956		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAY 23 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Leidner Undertaking Co		ADDRESS 2223 St. Louis Av		

(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.....
Signature of Student Embalmer

Signed.....
Robert M. Murray
Licensed Embalmer No. 3749

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.