

Health,
& Welfare
S. Public
th Service

S. 300
v. 1-56

Securing the medical certification in the specific manner required by 193.140 MoRS (1949).
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42018
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11191**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY 1					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Saint Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Length of stay in lb		d. STREET ADDRESS 4515 Ashland Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Albert Green				4. DATE OF DEATH Month 11 Day 19 Year 57					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1901		9. AGE (In years last birthday) 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Fayette, Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Albert Green Sr.				14. MOTHER'S MAIDEN NAME Flossie Stampley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 427-12-1317		17. INFORMANT Address Mrs. Lucille Green 4515 Ashland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia								INTERVAL BETWEEN ONSET AND DEATH undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 490+ DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atelectasis due to Unknown Cause - Pulmonary Emphysema								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 11-18-57 11:00P. to 11-19-57 8:30P. and last saw ^{xxx} him alive on 11-19-57 Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Sydney A. Mason M.D.				22b. ADDRESS 2601 Whittier Street				22c. DATE SIGNED 11-21-57	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Shipped		23b. DATE 11-23-57		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Jackson, Mississippi			
24. FUNERAL DIRECTOR ADDRESS Metropolitan Funeral System, Inc. 5010 Enright			25. DATE RECD. BY LOCAL REG. NOV 22 57		26. REGISTRAR'S SIGNATURE L. Earl Smith M.D.				

1000

St. Louis

Missouri

Home G. Phillips

Green

Alfred

Male

Age

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. - Cause of Death to be stated on reverse side of certificate.

Student _____
Signature of Student Embalmer

Signed *John K. Cunningham*

Licensed Embalmer No. *44*

11-18-24

xxx

11-18-24 8:30

11-18-24 11:00P

P. O. Address

2405 Ma

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.