

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007275
STATE FILE NUMBER
2328

FILED MAR 7 - 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 2328

Health, Welfare, Public Service, 300-1-56, Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

| | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|-------------------------------------|-----------------------------|--|-------|--|
| 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, give TOWNSHIP only) TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. 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 1b | | d. STREET ADDRESS 722 N. Garrison | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Lewis A. Green | | | | 4. DATE OF DEATH Month Day Year 2 24 58 | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-22-1881 | | 9. AGE (In years last birthday) 76 | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Arkansas | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME unknown | | | | | | | | |
| 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. - | | 17. INFORMANT Address Della Pringle 2613 Thomas St. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma 443 X | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH undet. | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 | | | | | | | | | | | | |
| 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 Month, Day, Year 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 2-21-58 to 2-24-58 and last saw him alive on 2-24-58 Death occurred at 12:15 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Dennie Leon Davis M.D. | | | | | | 22b. ADDRESS 2601 Whittier Street | | | 22c. DATE SIGNED 2-26-58 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 2-27-58 | | 23c. NAME OF CEMETERY OR CREMATORY Greenwood | | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | | | | | |
| 24. FUNERAL DIRECTOR Dement & Son 2629-31 Cole St. | | | | 25. DATE RECD. BY LOCAL REG. FEB 26 58 | | 26. REGISTRAR'S SIGNATURE J. C. Smith mo | | | | | | |

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 *W. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address *4575 Al*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.