

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023329
STATE FILE NUMBER

FILED JUN 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5854

5. 300
1-57

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All diseases in Part I must be causally related.

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 St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Webster Grove St. Rd.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Length of stay in lb 1 Mo.	d. STREET ADDRESS (If outside, give location) 723 S. Laclede St. Rd.
3. NAME OF DECEASED (Type or print) First Middle Last SISTER MARY IGNATIUS GREENE R.S.M.			4. DATE OF DEATH Month Day Year 6/4/58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sister of Mercy		10b. KIND OF BUSINESS OR INDUSTRY Convent	11. BIRTHPLACE (City and state or country) Allegheny City, Penn.
13a. FATHER'S NAME Joseph Greene		13b. MOTHER'S MAIDEN NAME Susana Brown	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address S. M. Magdalen Rm 307 S. Euclid Av
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis (Generalized)			INTERVAL BETWEEN ONSET AND DEATH years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			450.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 May 15 1958 to June 4 1958 and last saw her him alive on June 3rd 1959 . Death occurred at June 4th 1958 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. H. A. K. [Signature] (Degree or title)		22b. ADDRESS 3514 Central Clayton Mo	22c. DATE SIGNED 6-5-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/6/58	23c. NAME OF CEMETERY OR CREMATORY Sister of Mercy Convent	23d. LOCATION (City, town, or county) (State) Webster Grove, Mo.
24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd.		25. DATE RECD. BY LOCAL REG. JUN 5 '58	26. REGISTRAR'S SIGNATURE [Signature]

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 *Neal Morris*

Licensed Embalmer No. *3360*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.