

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028358

FILED VS. JUL 22 1960

318

1003

6934

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 10 Yes.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1700 a s. 10th St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1700A South 10th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lloyd Middle Green Last Green				4. DATE OF DEATH Month July Day 10, Year 1960					
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-5-1899	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during rest of waking life, even if retired) Night clerk			10b. KIND OF BUSINESS OR INDUSTRY Clerk		11. BIRTHPLACE (City and state or country) Evansville Indiana		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John N. Green			13b. MOTHER'S MAIDEN NAME Elizabeth Marks			14. NAME OF HUSBAND OR WIFE None			
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. 316-07-7237		17. INFORMANT Address Norman Green 1700A So. 10th 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) Pulmonary Edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) mitral insufficiency DUE TO (c) <input checked="" type="checkbox"/> 4HX							INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <input checked="" type="checkbox"/>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.) none					
20c. TIME OF INJURY none	Hour Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Feb 1960 to July 1960 and last saw her/him alive on July 10 1960 Death occurred at 9:10 A on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) H. G. Miller M.D.				22b. ADDRESS Exxon, Bidart St Kansas			22c. DATE SIGNED 7-4-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 12, 1960	23c. NAME OF CEMETERY OR CREMATORY Locust Hill		23d. LOCATION (City, town, or county) (State) Evansville Indiana				
24. FUNERAL DIRECTOR McLaughlin Funeral Home 2301 Lafayette Ave				25. DATE RECD. BY LOCAL REG. JUL 11 1960		26. REGISTRARS SIGNATURE Earl Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Miller
8410 N. 15th AVE
ONTARIO
9-11 A.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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