

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS OCT 17 1960

-60-037040

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2765 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN St. Louis	
Length of stay in 1b 1 year		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Halls-Ferry Memorial Home		d. STREET ADDRESS (If outside, give location) 1424 Angelica Street	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARY Middle A. Last GREEN			4. DATE OF DEATH Month Sept. Day 18, Year 1960		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/28/1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) New Orleans, La.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME WM. Cumberland	13b. MOTHER'S MAIDEN NAME Mary E. Moloney	14. NAME OF HUSBAND OR WIFE WM. Green (deceased)
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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. None	17. INFORMANT Address Alice Grote 5033 Arlington Ave (20)
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Congestive Heart Failure		5 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	
	DUE TO (c) Schility	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **January 1954** to **Sept. 18, 1960** and last saw her/him alive on **Sept. 18, 1960**
Death occurred at **5:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph Egan, M.D.	(Degree or title)	22b. ADDRESS 390 W. St. Anthony, Florissant	22c. DATE SIGNED 9/19/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/21, 1960	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, MO.
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24. FUNERAL DIRECTOR ADDRESS SUEDMEYER & SON'S 3934 N. 20th Street	25. DATE RECD. BY LOCAL REG. 9-19-60	26. REGISTRAR'S SIGNATURE Joseph B. Wierfling M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Harvey Kastle

Licensed Embalmer No. 4596

P. O. Address St Louis

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