

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3348

STATE FILE NUMBER

AMENDED

FILED APR 14 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|---|--|---|---------------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 11 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | c. CITY OR TOWN Pasadena Park | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 347 No. Hills Dr. | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HERBERT LEE GREEN | | | | | | 4. DATE OF DEATH Month Day Year April 6, 1961. | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 3/4/82 | | 9. AGE (last birthday) 79 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Educator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Public High School | | 11. BIRTHPLACE (City and state or country) Salisbury Tenn. | | 12. CITIZEN OF WHAT COUNTRY USA | | | |
| 13a. FATHER'S NAME James A. Green | | | | 13b. MOTHER'S MAIDEN NAME Minnie Wright | | | | 14. NAME OF HUSBAND OR WIFE Ruth Irene Gray | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 17. INFORMANT Address James G. Green 318 Tower Grove Dr. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | 332x | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Sarkinsons Disease | | | | | | | | 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 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. Month, Day, Year | | | | | | | | | | | |
| 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 11:25 to 4:6'61 and last saw him alive on 4:6'61 Death occurred at De Paul Hospital # 1145A on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Chris Jost M.D. | | | | | | 22b. ADDRESS 60006 Flourissant | | | 22c. DATE SIGNED 4.7.61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 23b. DATE 4/10/61 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory | | | 23d. LOCATION (City, town, or county) St. Louis County | | Mo. | | |
| 24. FUNERAL DIRECTOR Kellen Kelly | | | | | ADDRESS 7267 Natural Bridge | | 25. DATE RECD. BY LOCAL REG. APR 10 1961 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | |

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 James A. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.