SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

XC-1650052 SL 4401 -61-010875

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3252 STATE FILE NUMBER

FILED APR 14 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: 915 N GRAND, ST LOUIS, MO.
Length of stay in 1b: 26 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VAH, 915 NORTH GRAND
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3133 BELL
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: TOM; Middle: NMI; Last: GREEN

4. DATE OF DEATH: Month: APRIL; Day: 2; Year: 1961

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]

8. DATE OF BIRTH: 12/27/81

9. AGE (last birthday): 79

IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HR: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): SALEM, ILLINOIS

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: TOM GREEN

13b. MOTHER'S MAIDEN NAME: EDNA MITCHELL

14. NAME OF HUSBAND OR WIFE: - - - - - - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I

17. INFORMANT: ERNEST GREEN (BROTHER) #1 TOTTER COURT Address: ROSBERRY, MASS.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RENAL FAILURE

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): UNDETERMINED CAUSE
DUE TO (c): 593x

INTERVAL BETWEEN ONSET AND DEATH:

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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA attended the deceased from 3/7/61 to 4/2/61 and last saw him alive on 4/2/61

Death occurred at 2:25 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Nobuko O. Kulun M.D.

22b. ADDRESS: VAH, ST. LOUIS, MO.

22c. DATE SIGNED: 4/4/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 4-7-1961

23c. NAME OF CEMETERY OR CREMATORY: Gallman Chapel

23d. LOCATION (City, town, or county) (State): Hazelhurst, Copiah Co, Miss

24. FUNERAL DIRECTOR: J. H. RANDLE & SON ADDRESS: 3133 Bell Ave.

25. DATE RECD. BY LOCAL REG.: APR 6 1961

26. REGISTRAR'S SIGNATURE: Floyd Smith, M.D.

MEDICAL CERTIFICATION

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 Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Washi

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.