

FILED OCT 19 1945
Registration District No. **318**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Barnard Skin & Cancer Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME James Green

3. (b) If veteran, name war NIL

3. (c) Social Security No. NONE

4. Sex M. (1)

5. Color or race White

6. (a) Single, widowed, married, divorced, Separated

6. (b) Name of husband or wife Elizabeth Green

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased 6 20 1882
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>3</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace Scranton Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation unemployed

11. Industry or business _____

12. Name Michael Green

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Marjorie Brady

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Dominic Sgt. Hospital records

(b) Address 3427 Washington

17. (a) Removal
(Burial, cremation, or removal)

(b) Date thereof 10-5-45
(Month) (Day) (Year)

(c) Place: burial or cremation Carlinville, Ill

18. (a) Signature of funeral director Albert N. Napper

(b) Address OCT 8 2 1945 Washington Blvd

19. (a) _____
(Date received local registrar)

(b) J. F. Bredbeck
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill

(b) County Macoupin

(c) City or town Carlinville
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) N.R.

(e) Citizen of foreign country? _____ (Yes or No) 2

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4th
year 1945 hour 10:00 minute 20 P.M.

21. I hereby certify that I attended the deceased from Sept 22, 1945, to Oct 4th, 1945;
that I last saw him alive on Oct 4th, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Aspiration 3+ months

Due to Esophageal obstruction 5+ months

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Biopsy of esophageal lesion showed squamous carcinoma

Of autopsy no lesion found grossly had received 4-radiation

PHYSICIAN _____

Underline the cause to which death could be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

3. Signature Ralph Berg, Jr. (M. D. or other) M.D.

Address Barnard Hospital Date signed Oct 5

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John Aganosh

Licensed Embalmer No. *3398*

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