

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** APR 24 1946

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15150**  
Registrar's No. **35741**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 80 days  
(Specify whether  
In this community 43 yrs  
years, months or days)

3. (a) PRINT FULL NAME Green Rounsville  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race col 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased May 8th 1871  
(Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 6 If less than one day hr. min.

9. Birthplace Grenada Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business.....

12. Name Jack Rounsville

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

14. Maiden name Ann

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

16. (a) Informant Olivia Greene

(b) Address 4252 W Finney ave

17. (a) Burial (b) Date thereof 4-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J.H. Kandle, Son

(b) Address 3133 Bell Ave

19. (a) APR 18 1946 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 1117  
(d) Street No. 4252 W Finney  
(If rural, give location) 9  
(e) Citizen of foreign country?..... (Yes or No) 10  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14  
year 1946 hour 8 minute 20 A. M.

21. I hereby certify that I attended the deceased from Jan. 25 19 46 to April 14 19 46  
that I last saw him alive on April 14 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease

Duration Unk

Due to.....

Due to.....

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy None

PHYSICIAN

Underline the cause to which death should 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 injury) (e) Means of injury.....

23. Signature G. B. Williams (M. D. or other) 0

Address 2001 N Whittier Date signed 4/15/46

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

MOTHER FATHER

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**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.....

Licensed Embalmer No.....

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.**