

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31776**

**FILED 918**  
24 1945

Registrar's No. **8088**

Registration District No. ....

Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**

(a) County St. Louis Mo.  
 (b) City or town St. Louis Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Barnes Hospital, O  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 9 days  
 In this community 46 yrs  
 years, months or days (Specify whether)

**3. (a) PRINT FULL NAME** Nellie Green

3. (b) If veteran, name war  3. (c) Social Security No. ✓

4. Sex FEMALE 5. Color or race Cake 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife John Green 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased MAY 5 1900  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>4</u>	<u>13</u>	hr. _____ min.

9. Birthplace ST. LOUIS MO  
 (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name WILLIAM EVANS  
 13. Birthplace TROY MO  
 (City, town, or county) (State or foreign country)  
 14. Maiden name LUCY MORRIS  
 15. Birthplace LINCOLN CTY MO  
 (City, town, or county) (State or foreign country)

16. (a) Informant John Green  
 (b) Address 2711<sup>1/2</sup> Sheridan

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-46  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation WASHINGTON PARK

18. (a) Signature of funeral director A. J. Walton  
 (b) Address 2707 St. Louis

19. (a) SEP 19 1945 (Date received local health officer's certificate) (b) J. F. Bredeck (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County St. Louis  
 (c) City or town ST. LOUIS  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2711<sup>1/2</sup> SHERIDAN  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 18  
 year 1946 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from Sept. 9 1946 to Sept. 18 1946  
 that I last saw her alive on Sept. 18 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction following disease + Pulmonary embolism following myomectomy 9/13/46.  
 Due to Multiple myomata (benign)  
 Other conditions Coronary thrombosis  
 (Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: Multiple myomata  
 Of operations \_\_\_\_\_  
 Of autopsy As above

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 \_\_\_\_\_

23. Signature J. R. Bradley (M. D. or other) \_\_\_\_\_  
 Address Barnes Hospital. Date signed 9/18/46

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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.**