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5-17-39  
P 1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25544

FILED FEB 10 1947

Registrar's No. 000

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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:  
JOSEPHINE HEITKAMP HOSPITAL  
(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 \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County \_\_\_\_\_  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. Josephine Heitkamp Hos  
3022<sup>e</sup> N Union (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MICHAEL KEITH GREEN

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

4. Sex MALE 5. Color or race W  
6. (a) Single, widowed, married, divorced INFANT

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. JAN 27 - 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 1 hr. min.

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

10. Usual occupation NIL

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

12. Name THOMAS GREEN

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

14. Maiden name NADINE KINDER

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

16. (a) Informant Mr Thomas Green

(b) Address 3022<sup>e</sup> N Union Bldg

17. (a) BURIAL (b) Date thereof JAN 28/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buried Yalballa

18. (a) Signature of funeral director E. J. Schmu

(b) Address 3125 Lafayette Ave

19. (a) JAN 28 1947 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28  
year 1947 hour 12 minute 5 A.M.

21. I hereby certify that I attended the deceased from Jan 27 1947 to Jan 28 1947  
that I last saw him alive on Jan 28 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death. Intra-cranial injury Duration 1 day  
Due to Dystocia during labor  
Due to Breech presentation  
Other conditions. (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations W  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(c) 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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature Nathaniel Jordan (M. D. or other) MD  
Address 3903 Old St Date signed 1/28/47

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.....

*no Embalming*....., 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.**