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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED NOV 7 1947

Registration District No. 318

Primary Registration District No. 1003

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: St. Marys, In Firmly 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community Three days (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair-999
(c) City or town East St. Louis // (If outside city or town limits, write "RURAL")
(d) Street No. 1515 So. 19th Street 5 (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME Robert Greer

3. (b) If veteran, name war None 3. (c) Social Security No. 329-10-9988

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced 3
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 1st year 1907 (Day) (Year)
7. Birth date of deceased Oct. (Month) 1st (Day) 1907 (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>40</u>			<u>29</u>	____br.____min.

9. Birthplace Jackson Tenn. (City, town, or county) (State or foreign country)

10. Usual occupation Molder

11. Industry or business East St. Louis Casting

12. Name Frank Greer

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

14. Maiden name Yenna Cheatum

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

16. (a) Informant Bonnie Sittler

(b) Address EAST ST. LOUIS, ILL

17. (a) East St. Louis Ill (b) Date thereof 10-31-47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East St. Louis, Illinois

18. (a) Signature of funeral director [Signature]

(b) Address East St. Louis, Illinois

19. (a) OCT 28 1947 (b) J. Bredenk (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28th year 1947 hour 5 minute 22 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage in right
thoracic cavity following gunshot
wound of leg 2 1/2 inches
long and 1/2 inch deep
injury of same could not
be determined
Due to delirium

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

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) Gun Wound

(b) Date of occurrence 10-31-47

(c) Where did injury occur? 27 South (City or town) (County) (State)

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

While at work? _____ (Specify type of place) (e) Means of injury above 3

23. Signature Patrick E. Hayes (M. B. or other)

Address 1300 Clark Date signed 10-28-47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.