

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17298**
4555

FILED MAY 27 1949

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Bellemeade	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's		d. STREET ADDRESS (If rural, give location) 500 So. Kingshighway		
3. NAME OF DECEASED (Type or Print)		a. (First) Terrance Allen	b. (Middle) Greene	c. (Last) Greene
4. DATE OF DEATH (Month) (Day) (Year) 5-23-49		5. SEX male		6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH 5-18-49		9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Field, Ill.
12. CITIZEN OF WHAT COUNTRY? America		13a. FATHER'S NAME James J. Greene		
13b. MOTHER'S MAIDEN NAME Martha Carter		14. NAME OF HUSBAND FOR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		
17. INFORMANT'S SIGNATURE OR NAME James Greene - Bellemeade Ill		ADDRESS Bellemeade Ill		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Polycystic Kidneys		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		
		DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 137th
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 7591
22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1820th m., from the causes and on the date stated above.				
23a. SIGNATURE William G. Skillingberg MDU		23b. ADDRESS 500 So. Kingshighway		23c. DATE SIGNED 5-23-49
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 5-25-1949		24c. NAME OF CEMETERY OR CREMATORY MT. ROSE
24d. LOCATION (City, town, or county) (State) FRIENDSHIP Wisc.		25. FUNERAL DIRECTOR'S SIGNATURE W. B. Sasator		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 24 1949		ADDRESS Bellemeade Ill		

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

BODY NOT EMBALMED.

Signed.....

[Handwritten Signature]

..... Licensed Embalmer No.

Signed.....
Student Embalmer

..... 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.