

FILED APR 20 1951

STANDARD CERTIFICATE OF DEATH

14137

State File No. 3228

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) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place)		2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION 812 N. 9th ST.		d. STREET ADDRESS (If rural, give location) 812 N 9th ST. 0	

3. NAME OF DECEASED (Type or Print) SARAH GREEN			4. DATE OF DEATH (Month) (Day) (Year) 4 - 3 - 1951		
5. SEX 3 FEMALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1	8. DATE OF BIRTH MAY 25, 1900		9. AGE (In years last birthday) 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HOT SPRINGS, ARK. 1		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME unk		13b. MOTHER'S MAIDEN NAME unk		14. NAME OF HUSBAND OR WIFE HENRY GREEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME HENRY Green-812 N 9	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Kly Peritonitis Valvular Heart Dis. 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.		INTERVAL BETWEEN ONSET AND DEATH 12mo	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	

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? 4214	
22. I hereby certify that I attended the deceased from Mar 5, 1950 to Mar 28, 1951, that I last saw the deceased alive on 3-28, 1951, and that death occurred at 2-30 P.M., from the causes and on the date stated above.					

23a. SIGNATURE Samuel Stoddard M.D.		23b. ADDRESS 925 N. Jefferson Ave		23c. DATE SIGNED 4-4-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4-10-51		24c. NAME OF CEMETERY OR CREMATOR ST. PETER'S CEMETERY	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CITY MO		25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON 2707 STODDARD ST			
DATE REC'D BY LOCAL REG. APR 6 1951		REGISTRAR'S SIGNATURE J. B. Kasater		ADDRESS	

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Arthur L. Heilind*

Signed.....

Student Embalmer

Licensed Embalmer No. 4221

P. O. Address

4740<sup>a</sup> Complex Pl

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.