

FILED JUL 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24860

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1490

1. PLACE OF DEATH a. COUNTY St. Louis 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) Affton	c. LENGTH OF STAY in this place 10 mos.	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Miller Nursing Home		STREET ADDRESS (If rural, give location) 3833 Iowa Ave. 2249	

3. NAME OF DECEASED (Type or Print) a. (First) Myron	b. (Middle) A.	c. (Last) Green	4. DATE OF DEATH (Month) (Day) (Year) June 29, 1955
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3-21-1875	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	Hours _____	Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager	10b. KIND OF BUSINESS OR INDUSTRY Express Company	11. BIRTHPLACE (City and State or Foreign Country) Truxton, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Myron A. Green	13b. MOTHER'S MAIDEN NAME Mary Pew	14. NAME OF HUSBAND OR WIFE Flora
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish-American	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louella Creissen 4939 Sunshine Dr.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Acute Myocarditis and Chronic		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Interstitial Nephritis		3 Mo.
	DUE TO (c) Arteriosclerosis		6 Mo.

19a. DATE OF OPERATION No	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 592 X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec. 22, 19 54, to June 29th 55, that I last saw the deceased alive on June 27, 19 55, and that death occurred at 8:45pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>W. Hatter M.D.</i>	23b. ADDRESS 3608 S. Grand Blvd.,	23c. DATE SIGNED 6/30/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-1-55	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
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DATE REC'D BY LOCAL REG. 6/30/55	REGISTRAR'S SIGNATURE <i>Herbert P. Domb</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John L. Ziegenhein & Sons 7027 Gravois
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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..

Student
Signature of Student Embalmer

Signed *G. P. Kidwell*

Licensed Embalmer No. *387*

P. O. Address *7027 Grand*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.