

FILED SEP 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28447

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6924**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE ILLINOIS b. COUNTY MADISON	
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 GRANITE CITY	
c. LENGTH OF STAY (In this place) 1 WK		d. STREET ADDRESS (If rural, give location) 2419 CLEVELAND BLVD.	
d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) RUBIE	b. (Middle) A.	c. (Last) GREENE	4. DATE OF DEATH (Month) (Day) (Year) 7 25 1956
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH 10-31-1882	9. AGE (In years last birthday) 73	# UNDER 1 YEAR	# UNDER 1 MONTH	# UNDER 1 MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) WHITE HALL, ILLINOIS	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME WM. R. GREENE	13b. MOTHER'S MAIDEN NAME MARY FRANCIS	14. NAME OF HUSBAND OR WIFE
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Bonnie Miller 2419 Cleveland Blvd Granite City Ill
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure		
	ANTECEDENT CAUSES DUE TO (b) Hypertension DUE TO (c)		
II. 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 443 x	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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?

22. I hereby certify that I attended the deceased from **7-18-56**, 19___, to **7-25-56**, 19___, that I last saw the deceased alive on **7-25-56**, 19___, and that death occurred at **12-29-56** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Earl Smith	23b. ADDRESS 4930 Lindell Blvd.	23c. DATE SIGNED 7-26-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 7-25-1956	24c. NAME OF CEMETERY OR CREMATORY SUNSET HILL	24d. LOCATION (City, town, or county) (State) EDWARDSVILLE, ILLINOIS
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DATE REC'D BY LOCAL REG. JUL 26 1956	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Frank Mercer Granite City Ill
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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.

Student
Student Embalmer

Signed

Charles E. Merce

Licensed Embalmer No. *2988*

P. O. Address

Granite City, Mo.

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.