

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33563**
Registrar's No. **8357**

FILED SEP 17 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before —a. STATE Mo. b. COUNTY _____ (admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN City, St. Louis		c. LENGTH OF STAY (In this place) 2 yrs. 8 mo.	c. CITY OR TOWN City, St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.		e. STREET ADDRESS (If rural, give location) 2642 LaSalle St.	
3. NAME OF DECEASED (Type or Print) a. (First) Laura b. (Middle) Green c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 9- 3- 57	
5. SEX Female	6. COLOR OR RACE Colered	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH April 9, 1890
9. AGE (In years less birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	11. BIRTHPLACE (City and State or Foreign Country) Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME unk.	
13b. MOTHER'S MAIDEN NAME Linda Little		14. NAME OF HUSBAND OR WIFE Deceased	
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 Mr. Flozell Green		ADDRESS 2642 LaSalle St.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pt. Lower Lobar Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 490x	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. INTERVAL BETWEEN ONSET AND DEATH 11 days.		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) (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 12-13-54 , 19____, to 9- 3- , 19 57 , that I last saw the deceased alive on 9- 3- , 19 57 , and that death occurred at 4:45 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.		23b. ADDRESS 5800 Arsenal St.	
23c. DATE SIGNED 9/4/57		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 9/9/1957		24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry	
25. ADDRESS 4202 Finney Ave.		DATE REC'D BY LOCAL REG. SEP 6 57	

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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 *Leroy U. Bonnieste*

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.

U. S. A.