

TRANS. FROM LINCOLN
MEMORIAL HOSP., TROY, MO.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015040

STATE FILE NUMBER
2 No 3834

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY **Lincoln**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Mo.** Inside Limits Yes No

c. CITY OR TOWN **Elsberry** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Louis Childrens** Length of stay in 1b **5 hrs.**

d. STREET ADDRESS (If outside, give location) **601 N. 3rd St.** Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last
Baby Boy Green

4. DATE OF DEATH Month Day Year
4 17 59

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH **4-16-59** 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
1

10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Troy, Missouri** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Martin Austin Green** 13b. MOTHER'S MAIDEN NAME **Muriel Paap** 14. NAME OF HUSBAND OR WIFE **None**

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 **Luan Lehr, 500 S. Kingshighway** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Severe atelectasis** INTERVAL BETWEEN ONSET AND DEATH **since birth**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) **762.5**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Premature** 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **4-17-59** to **4-17-59** and last saw him alive on **4-17-59**
Death occurred at **3:30 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *[Signature]* 22b. ADDRESS **500 S. Kingshighway** 22c. DATE SIGNED **4-17-59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **4-18-59** 23c. NAME OF CEMETERY OR CREMATORY **Local** 23d. LOCATION (City, town, or county) (State) **Elsberry, Missouri.**

24. FUNERAL DIRECTOR **Ricks Funeral Home, Elsberry, Missouri.** ADDRESS 25. DATE RECD. BY LOCAL REG. **APR 18 59** 26. REGISTRAR'S SIGNATURE *[Signature]*

5. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Edna C. Baxter
Signed **NO EMBALM**

Licensed Embalmer No.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

• If this body is not embalmed, fact should be so stated above.