

1. PLACE OF DEATH
 a. COUNTY Missouri
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Length of stay in 1b _____
 c. FULL NAME OF (If NOT in hospital, give location of HOSPITAL OR INSTITUTION) OOA Home Phyllis Inside Limits Yes No
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo. b. COUNTY _____
 c. CITY OR TOWN ST. LOUIS Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 3843A Windsor Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last CAROLYN OPHELIA GREEN
 4. DATE OF DEATH Month Day Year NOV - 9 - 1960
 5. SEX FEMALE 6. COLOR OR RACE NEGRO 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 11-2-1960 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min. 7
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Any 10b. KIND OF BUSINESS OR INDUSTRY _____
 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME ALOYZO WILFRED GREEN 13b. MOTHER'S MAIDEN NAME GREENLEE 14. NAME OF HUSBAND OR WIFE Baby
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Not Any 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Address Mr. A.W. GREEN 3843A Windsor

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Suppexation. Suffered in bed in home on November 9, 1960 no plaques involved. Accident 924.0-18
 DUE TO (b) _____
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

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.) See above
 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 11-9-60
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
 20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo

21. I attended the deceased from _____ to _____ and last saw her/him live on _____
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Deputy 22b. ADDRESS 1200 Clark 22c. DATE SIGNED 11-10-60

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 11-12-1960 23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON KIRKWOOD 23d. LOCATION (City, town, or county) (State) MO.
 24. FUNERAL DIRECTOR ADDRESS Moses Adams 3849 Windsor 25. DATE RECD. BY LOCAL REG. NOV 10 1960 26. REGISTRAR'S SIGNATURE Loan Smith. M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delma

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.