

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035285

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2597

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORMANDY</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SULLIVAN NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>1627 S. 9th ST.</u>	
Length of stay in 1b <u>YRS.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>MAE</u> Last <u>GREEN</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>13</u> Year <u>1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 17 1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>BENJAMIN VINSON</u>		13b. MOTHER'S MAIDEN NAME <u>MARY JANE COX</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES T. GREEN SR.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>LAVERNE HAYNER FERGUSON Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Gangrene left leg</u>			<u>1 month</u>
DUE TO (b) <u>Cerebral hemorrhage - left hemiplegia</u>			<u>6 months</u>
DUE TO (c) <u>Hypertensive and Cardiovascular Disease</u>			<u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Brain Syndrome 443x</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <u>3/29/59</u> to <u>9/13/61</u> and last saw her <u>alive</u> on <u>9/12/61</u> Death occurred at <u>1015A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Describe or title) <u>Thomas L. Kuter MD</u>		22b. ADDRESS <u>8231 Clayton Rd (17) Mo</u>	22c. DATE SIGNED <u>9/15/61</u>
23a. BURIAL, CREMATION, or other disposition <u>BURIAL</u>	23b. DATE <u>SEPT. 15 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
24. FUNERAL DIRECTOR <u>Thomas Kuter 2906 Graciers</u>	25. DATE RECD. BY LOCAL REG. <u>9-14-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Eleanora Bonine

Licensed Embalmer No. 3403

P. O. Address 2906 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.