

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036199

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9132**

FILED SEP 28 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2 *20*

3

4 *1*

5 *1*

6

7 *0*

8 *2*

9

10

11

12 *68-0*

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 Days</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.      b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4256 N. Florissant</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First <b>Willa</b>	Middle <b>Lee</b>	Last <b>Green</b>	4. DATE OF DEATH Month      Day      Year <b>Sept.      21      1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/1897</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months      Days	IF UNDER 24 HR Hours      Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Lincoln County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Walter E. Guinn</b>			13b. MOTHER'S MAIDEN NAME <b>Phoebie Jane Hardy</b>			14. NAME OF HUSBAND OR WIFE <b>Ray A. Green</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. Ray A. Green</b>		Address <b>4256 N Florissant</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>with intractable congestive FAILURE</b> DUE TO (b) <b>ANEMIA - secondary</b> DUE TO (c) <b>DIABETES MELLITUS</b> <b>260x</b>								INTERVAL BETWEEN ONSET AND DEATH	
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. <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      SUICIDE      HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.      Month, Day, Year p.m.		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 <b>9-18-62</b> , to <b>Sept 21, 62</b> and last saw <sup>her</sup> alive on <b>9-21-62</b> Death occurred at <b>11 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Loann M. ... MD</i> (Degree or title)					22b. ADDRESS <b>St. Louis, Mo</b>			22c. DATE SIGNED <b>9-21-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-24-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>			(State)	
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons</b>				ADDRESS <b>6175 Delmar Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 21 1962</b>		26. REGISTRAR'S SIGNATURE <i>Loann Smith M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

Dr. W. M. Lonergan  
457 N Kingshighway  
Fo 1-3116

**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 James E. McCullough

Licensed Embalmer No. 2460

P. O. Address St. Lawrence

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.