

791

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
3417 McCausland Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3417 McCausland Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Anna A. Grant

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26th  
year 1940 hour 8 minute P.M. M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nils Grant

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

7. Birth date of deceased: April 4<sup>th</sup> 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec.  
9, 1939, to Nov. 26, 1940  
that I last saw her alive on Nov. 26, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years 71 Months 7 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Sweden  
(City, town, or county) (State or foreign country)

Duration

Carcinoma of right lobia 1 yr.

Due to major - Primary

Due to H/S

10. Usual occupation H.W.K.

11. Industry or business \_\_\_\_\_

12. Name 2. CARL - Hallberg

13. Birthplace Sweden  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Sweden  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)  
Carcinoma involving entire abdomen

Major findings: none

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Nils Grant

(b) Address 3417 McCausland Ave.

17. (a) Cremation (b) Date thereof 11-29-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Kriegshauser Mortuar  
es

(b) Address 4229 So. Kingshighway Blvd.

19. (a) NOV 28 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature J. P. Emerald MD  
(M.D. or other)

Address 1200 Columbia Ave Date signed 11/27/40

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

Mr. J. P. Mennich  
6200 Delmarvic Ave  
9-10

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed... *Edwin M. Mennich*

Licensed Embalmer No. *3084*

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