

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

FEB 25 1941
Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:—

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Fairmont Hotel
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME GRACE MARY WHITE

3. (b) If veteran, name war none **3. (c) Social Security No.** none

4. Sex female **5. Color or race** white **6. (a) Single, widowed, married, divorced, widowed** widowed

6. (b) Name of husband or wife Fredrick C. White **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased April 7, 1861.
(Month) (Day) (Year)

8. AGE:

| | | | |
|-------|--------|------|----------------------|
| Years | Months | Days | If less than one day |
| 79 | 8 | 29 | _____ hr. _____ min. |

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

10. Usual occupation at home

11. Industry or business _____

12. Name David Block

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

14. Maiden name _____

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

16. (a) Informant's own signature Harry M. White
(b) Address 304 Edgewood Dr.

17. (a) burial **(b) Date thereof** 1-7-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director C. R. Lupton & Sons
(b) Address 7233 Delmar, St. Louis, Mo

19. (a) JAN 6 1941 **(b)** J. F. Budek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4907 Mervland Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5th
 year 1941 hour 6 minute 45 **A. M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h_____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Arterio-sclerosis

Due to Hypertension

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

PHYSICIAN _____
 Underline the cause to which death should be charged statistically

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
no

While at work? no (Specify type of place) **(e) Means of injury** no

23. Signature W. H. Schwarz (M. D. or other)
Address 440 N. Newcastle **Date signed** 1-5-40

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 Clarence A. Murray
Licensed Embalmer No. 40110
P. O. Address St. Louis, Mo

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, above space should be left blank.