

No. 2  
-13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27148

State File No. ....

Primary Registration District No. 791  
District No. 1003

Primary Registration District No. 1003

Registrar's No. 6940

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

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: Homer G. Phillips Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 34 Min.  
(Specify whether  
In this community. 23 Yrs.  
years, months or days)

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") 1121  
(d) Street No. 2106 Division  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A? ..... years.

3. (a) PRINT FULL NAME Lawrence Grinston

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced. ( )

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive years

7. Birth date of deceased 7 28 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 hr. 46 min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name John Grinston

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

14. Maiden name Margaret Clendening

15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Father, Mary Sherard

(b) Address 2601 N. Whittier St.

17. (a) (b) Date thereof 8-28-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Mrs. Hamilton

(b) Address City Health Dept

19. (a) AUG 27 1941 (b) J. W. Probeck  
(Date of registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7th day 28th  
year 1941 hour 11 minute 05 P.M.

21. I hereby certify that I attended the deceased from July 28, 1941, to July 28, 1941

that I last saw him alive on July 28, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia, Hydrocephalus Patent Foramen Ovale

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 151

Major findings: Of operations.....

Of autopsy AS ABOVE

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 Lewis J. Hodder (D. or other) 01

Address 2601 N. Whittier Date signed 8/26/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

Licensed Embalmer No.....

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.**