

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24733

6281

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>1317 Monroe St.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Gideon</b>	b. (Middle)	c. (Last) <b>De Grant</b>	4. DATE OF DEATH (Month) (Day) (Year)
				<b>7 18 49</b>

5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>March 24-1886</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <b>John De Grant</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah De Grant</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Rose De Grant</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Frances Fuller 1227 Clinton St</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Mesenteric thrombosis ruptured</b> <b>Chronic Myocarditis while being hospitalized as a result of injuries received when a building collapsed as a result of leaking gas at the southeast corner of 13th &amp;</b>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>injuries received when a building collapsed as a result of leaking gas at the southeast corner of 13th &amp;</b> DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Clinton around 4:15 pm May 18, 1949 Accident</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Building</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Mo E 9103</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>May 18 49 4:15 p.m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4 46</b>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred at **2:15 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Petruck L Taylor Cur.</b>	23b. ADDRESS <b>1500 Clark</b>	23c. DATE SIGNED <b>7-19-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-21-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>
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DATE REC'D BY LOCAL REG. <b>III 19 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hy. Leidner U. 2223 St. Louis Ave.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 .....  
Student Embalmer

Signed John P. Beckholz

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis

**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.