

FILED JAN 19 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2379
State File No.
126
Registrar's No.

318 1003

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) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2059		
d. FULL NAME OF HOSPITAL OR INSTITUTION 5620 Chamberlain Ave.				d. STREET ADDRESS (If rural, give location) 5620 Chamberlain Ave.				
3. NAME OF DECEASED (Type or Print) a. (First) Agnes b. (Middle) Grant c. (Last) Brennan			4. DATE OF DEATH (Month) (Day) (Year) Jan. 5, 1951					
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Mar. 26, 1864		9. AGE (In years, last birthday) 86	IF UNDER 1 YEAR Months Days	IF UNDER 10 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME William D. Grant			13b. MOTHER'S MAIDEN NAME Margaret Riordan		14. NAME OF HUSBAND OR WIFE William J. Brennan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Clarence Brennan				ADDRESS 5620 Chamberlain Ave.
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage (Hypertension) INTERVAL BETWEEN ONSET AND DEATH 5 days ANTECEDENT CAUSES Cardiovascular Disease DUE TO (b) 5 years 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					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Asst				
22. I hereby certify that I attended the deceased from Jan 20 , 19 50 , to Jan 5 , 19 51 , that I last saw the deceased alive on Jan 5 , 19 51 , and that death occurred at 3:30 P.m. , from the causes and on the date stated above.								
23a. SIGNATURE Dr. James J. Langon M.D.				23b. ADDRESS 5803 Plymouthea		23c. DATE SIGNED Jan 6-50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 8, 51	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. JAN 7 1951		REGISTRAR'S SIGNATURE J. B. Lisater		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly				ADDRESS 3840 Lindell Blvd

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

W H Van Matre

Signed
Student Embalmer--

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.