

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

State File No. 15134

FILED APR 27 1951

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>862</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koch (rural)</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2157</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4200 So. Broadway</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>PATRICK</u>			b. (Middle) <u>-</u>		c. (Last) <u>Grant</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 18, 1892</u>		9. AGE (In years last birthday) <u>58yrs</u>	IF UNDER 1 YEAR Months <u>2</u> Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd Jobs</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Grant</u>			13b. MOTHER'S MAIDEN NAME <u>Mary BERRY</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>??</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert Grant 15039 Wells Ave. Hosp.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Constrictive pericarditis due to tuberculosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>002X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1-19-</u> , 19 <u>51</u> , to <u>4-1-</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4-1-</u> , 19 <u>51</u> , and that death occurred at <u>4:20P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>E. J. Schmeis</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Robert Koch Hospital</u>		23c. DATE SIGNED <u>4-2-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>APRIL-4-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>		
DATE REC'D BY LOCAL REG. <u>4/3/51</u>		REGISTRAR'S SIGNATURE <u>Robert P. Lomke M.D.</u>		FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schmeis</u>		ADDRESS <u>3125 Lafayette Av.</u>	

(Licensed Embalmer's Statement of Reverse Side)

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

Joseph B. Solmer

Licensed Embalmer No. 4914

P. O. Address 3125 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.