

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

State File No. **35087**

FILED NOV 8 1951

REGISTRAR'S NO. **9454**

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	REGISTRAR'S NO. 9454
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) 23 yrs		
d. FULL NAME OF HOSPITAL OR INSTITUTION 2723 A. Mills St.		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
3. NAME OF DECEASED (Type or Print) Sylvia		a. (First) _____ b. (Middle) _____ c. (Last) Grayson		4. DATE OF DEATH (Month) (Day) (Year) Oct, 24, 1951
5. SEX Female 3	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH June 16, 1889	9. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil.		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) J Leflore County Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Marshall Shaw		13b. MOTHER'S MAIDEN NAME Mary ?	14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Lennie Reed ADDRESS 2831 Gamble St.	
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) Cardio Renal disease ANTECEDENT CAUSES Hypertension & Chronic Nephritis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Hypertension - Nephritis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. /		INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? 4/12/51		
22. I hereby certify that I attended the deceased from 10-13-1951 to 10-24-1951 , that I last saw the deceased alive on Oct, 24, 1951 , and that death occurred at 8:00 a.m. , from the causes and on the date stated above.				
23a. SIGNATURE J. F. Whitaker (Degree or title) 0		23b. ADDRESS 2743 Franklin		23c. DATE SIGNED 10-24-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 27, 1951	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.	
DATE REC'D. BY LOCAL REG. OCT 26 1951	REGISTRAR'S SIGNATURE J. Earl Smith - Mo	25. FUNERAL DIRECTOR'S SIGNATURE Wright Funeral Home ADDRESS 3100 Easton Ave.		

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 *Arthur L. Hollman*

Signed.....
Student Embalmer

Licensed Embalmer No. *4221*

P. O. Address *4740 Campbell*

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.