

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18039
18039
Registrar's No. 1003

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2209</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>20 2835 Madison</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) _____ c. (Last) <u>Grant</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 27 1952</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Nov. 27, 1892</u>
9. AGE (In years last birthday) <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>
13a. FATHER'S NAME <u>John Grant</u>		13b. MOTHER'S MAIDEN NAME <u>Mary West</u>	14. NAME OF HUSBAND OR WIFE <u>XXXXXXXX</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1906 to 1909</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Mary Shorter 2835 Madison Ave</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u> ANTECEDENT CAUSES DUE TO (b) <u>Undetermined</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Heart Disease</u>	
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) _____	
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 checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>ROCK</u>			
22. I hereby certify that I attended the deceased from <u>4-14</u> , 19 <u>52</u> , to <u>4-27</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>52</u> , and that death occurred at <u>2:43p m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Loren W Harris</u> (Degree or title) <u>M. D.</u>		23b. ADDRESS <u>2601 N Whittier St</u>	
23c. DATE SIGNED <u>4-28-52</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barrack Mo</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5/2/52</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Barracks</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barrack Mo</u>	
DATE REC'D BY LOCAL REG. <u>APR 30 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman J. Smith</u>		ADDRESS <u>4247/w Labadie</u>	

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 K. Cunningham

Licensed Embalmer No. *4476*

P. O. Address *4273 Emory*

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.