

FILED JUL 15 1952

STANDARD CERTIFICATE OF DEATH

State File No. 22055

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6173

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2059	
c. LENGTH OF STAY (In this place) 2 days		d. STREET ADDRESS (If rural, give location) 5 5745 Enright	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific			

3. NAME OF DECEASED (Type or Print) CLARA GRANT		4. DATE OF DEATH June 28, 1952	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH July 12, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (City and State or Foreign Country) Greenville Mo.
			12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME C.O. Collins	13b. MOTHER'S MAIDEN NAME Mary Cline	14. NAME OF HUSBAND OR WIFE John A. Grant
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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 John A. Grant	ADDRESS 5745 Enright St. Louis
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Hypertensive Heart Disease sev.</i>		
	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 type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <i>443X</i>
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22. I hereby certify that I attended the deceased from *June 27, 1952* to *June 28, 1952*, that I last saw the deceased alive on *June 27, 1952* and that death occurred at *5:30 PM*, from the causes and on the date stated above.

23a. SIGNATURE <i>L. B. Harrison M.D.</i>	(Degree or title)	23b. ADDRESS <i>607 husband</i>	23c. DATE SIGNED <i>6-28</i>
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24a. BURIAL, CREMATION REMOVAL (Specify) <i>Removal</i>	24b. DATE June 28, 1952	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) DeSoto, Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 30 1952 <i>Charles Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Motherhead F. Home</i>	ADDRESS DeSoto Mo.
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(Licensed Embalmer's Statement on 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 John Lee Matherhead

Licensed Embalmer No. 3581

P. O. Address De Soto, Mo.

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.