

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6240

State File No. _____

0900

FILED MAR 4 1954

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

1. PLACE OF DEATH a. CITY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Mt. Vernon	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) St. Louis, Missouri Cherry St. 8	

3. NAME OF DECEASED (Type or Print)	a. (First) LENA	b. (Middle) (NMN)	c. (Last) GROOMS	4. DATE OF DEATH (Month) (Day) (Year) JANUARY 22, 1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 9-1-1922	9. AGE (In years last birthday) Months Days 31	10. UNDER 1 YEAR Hours Min.	11. UNDER 1 HRS.
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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) Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Harry McKinley	13b. MOTHER'S MAIDEN NAME Connie Shipp	14. NAME OF HUSBAND OR WIFE Northern Grooms
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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 Northern Grooms, Mt. Vernon, Ill.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE HEPATITIS		
	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 checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 092x
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22. I hereby certify that I attended the deceased from **JAN 22, 1954**, to **JAN 22, 1954**, that I last saw the deceased alive on **JAN 22, 1954**, and that death occurred at **2:55 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>I David W. Kerr MD</i>	(Degree or title)	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 1-22-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1-22-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Centralia, Ill.
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DATE REC'D BY LOCAL REG. JAN 29 1954	REGISTRAR'S SIGNATURE <i>J. Charles Smith MD</i>	25. FUNERAL DIRECTOR'S SIGNATURE Queen Boggs, Centralia, Ill.	ADDRESS
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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.....
Signature of Student Embalmer

Signed *W E Morris*

Licensed Embalmer No. 33

P. O. Address *St Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.