

FILED MAR 7 1955

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6189

BIRTH NO. 91463-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1454

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. LENGTH OF STAY (In this place) 1 mo. 3 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Omer G. Phillips 0		d. STREET ADDRESS 2257		(If rural, give location) 1422 N. 18th	
3. NAME OF DECEASED (Type or Print) Diane		a. (First)		b. (Middle)	
		c. (Last) Grinston		4. DATE OF DEATH (Month) (Day) (Year) 1 24 55	
5. SEX Fem. 3		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH 12-22-54		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri 0	
13a. FATHER'S NAME George Grinston		13b. MOTHER'S MAIDEN NAME Dorothy Scott		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Kathleen M. Sheward, CRP	
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) Meningeal Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined Organ (Subarachnoid) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Encephalopathy due to Anoxia, Hemoptysis, Diarrhea due to Coliform Organism, Premature birth.		INTERVAL BETWEEN ONSET AND DEATH	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 3568	
22. I hereby certify that I attended the deceased from 12-22-1954 to 1-24-1955, that I last saw the deceased alive on 1-24-1955, and that death occurred at 6:15 p. m., from the causes and on the date stated above.					
23a. SIGNATURE William H. Linker M. D.		(Degree or title) 0		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 1-26-55		24a. BURIAL, CREMATION, REMOVAL (Specify) 2-28-55		24b. DATE 2-28-55	
24c. NAME OF CEMETERY OR CREMATORY Anatomical Beata		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Kowland-Aker Mortuary Service	
DATE REC'D BY LOCAL REG. FEB 16 1955		REGISTRAR'S SIGNATURE Carl Smith		ADDRESS 4104 St. Charles Ave. St. Louis 10, Mo.	

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.....

Licensed Embalmer No.....

P. O. Address.....

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.