

FILED JUN 7 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17919**
4905
Registrar's No.

BIRTH NO. **33425-56** 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 Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (In this place) 4 hrs 5 mins		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wm. G. Phillips		e. STREET ADDRESS (If rural, give location) 12 4554 Delmar		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Willie		b. (Middle)		c. (Last) Grant	
4. DATE OF DEATH 4 27 56		4. DATE (Month) (Day) (Year)		5. SEX Male	
6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 4-27-56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 4 5	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday) 4 5	
13a. FATHER'S NAME Oscar Grant		13b. MOTHER'S MAIDEN NAME Mary Lee Turner		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Margt. J. R. R. L.	
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* Pneumonia, Aspiration		ADDRESS 2601 N. Whittier	
ANTECEDENT CAUSES DUE TO (b) Atelectasis		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS -Conditions contributing to the death but not related to the disease or condition causing death.		7630		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		7625	
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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-27- 19 56 to 4-27- 19 56 that I last saw the deceased alive on 4-27- 19 56 , and that death occurred at 6:30 PM , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) William H. Sinkler M. D. C.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 5-1-56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 5-31-56		24c. NAME OF CEMETERY OR CREMATORY Anatomical Home	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		24e. NAME OF CEMETERY OR CREMATORY		24f. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. MAY 22 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service	

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.....

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