

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011766
STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 909

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Tennessee</u> b. COUNTY <u>Shelby</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Wellston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Memphis</u> 8 46 8
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent's Hosp.</u>		Length of stay in 1b <u>22 days</u>	d. STREET ADDRESS (If outside, give location) <u>Gilmore Apartments</u>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Grymes</u>			4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1885</u>
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of last life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Croghan</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Flaherty</u>		14. NAME OF HUSBAND OR WIFE <u>Unavailable</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Jane G. Patton, daughter,</u> <u>5104 N. Angela, Memphis, Tennessee</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pulmonary Congestion</u> <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cardiac Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 days</u> <u>Years</u> <u>"</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>331X</u>	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Mar. 12, 1959</u> to <u>April 3, 1959</u> and last saw her alive on <u>April 3, 1959</u> Death occurred at <u>5:10 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>F. E. Kretsch</u> M.D.		22b. ADDRESS <u>7301 St. Charles Rock Rd.</u>	22c. DATE SIGNED <u>4/3/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4-4-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>
23d. LOCATION (City, town, or county) (State) <u>Memphis Tenn</u>		24. FUNERAL DIRECTOR <u>Albert H. Hoppe 4700 Washington</u>	
25. DATE RECD. BY LOCAL REG. <u>4-4-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy, MD</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Journey Zable*

..... Licensed Embalmer No. 4596
P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.