

FILED VS MAR 13 1961

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2035-61-010870

Registration District No. Primary Registration District No. Registrar's No. STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis Children's</b>		Length of stay in lb <b>23 days</b>		c. CITY OR TOWN <b>Edwardsville</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Children's</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>741 Troy Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Mathew</b> Last <b>Grant</b>			4. DATE OF DEATH Month <b>2-</b> Day <b>25</b> Year <b>61</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-31-60</b>	9. AGE (last birthday) <b>1 1/2</b>	IF UNDER 1 YEAR Months <b>1 1/2</b> Days	IF UNDER 24 HR Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>Highland Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Paul Grant</b>			13b. MOTHER'S MAIDEN NAME <b>Marilyn Stilts</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mary Ritter 500 S Kingshighway</b> 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) <b>Cardiac Arrest</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)		DUE TO (b) <b>Brain Damage 2<sup>o</sup> post mature birth &amp; difficult delivery</b>					
		DUE TO (c) <b>pneumonia</b>				<b>76.0.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the proximal disease condition given in PART I. <b>congestive heart failure</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)			
20c. TIME OF INJURY Hour <b>10:35</b> a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>1-2-61</b> to <b>2-25-61</b> and last saw her <sup>him</sup> alive on <b>2-25-61</b> Death occurred at <b>10:35 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Superna M. Turner, MD</i> (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
23a. BURIAL, CREATION, REMOVAL (Specify)		23b. DATE <b>2-28-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>McGee Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Wayne County, Mo.</b>		
24. FUNERAL DIRECTOR <b>Wm H. Marquon Advancer, Inc.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>FEB 28 1961</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

**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 not embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wm H May

Licensed Embalmer No. 4640

P. O. Address Advance, 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.