

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036203

STATE FILE NUMBER

318

1003

8903

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8903

FILED SEP 24 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 12 yr 5 mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Mo.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5004 Arsenal St.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Athel P. Greive						4. DATE OF DEATH Month Day Year September 13, 1962					
5. SEX F		6. COLOR OR RACE W		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/20/76		9. AGE (last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Wm. Burgoine Jones				13b. MOTHER'S MAIDEN NAME Mary Hunter				14. NAME OF HUSBAND OR WIFE Henry M. Grieve			
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 Masonic Home of Mo. 5351 Delmar Blvd. <i>Luise Rabe</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis acute</i>										INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Generalized arteriosclerosis</i>										unknown	
DUE TO (c) <i>4201</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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.) ---							
20c. TIME OF INJURY Hour 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 <i>4/14/50</i> to <i>9/13/62</i> and last saw her <del>xxx</del> alive on <i>9/13/62</i> Death occurred at <i>7:00 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Harold E. Walters M.D.</i>						22b. ADDRESS <i>3720 Washington St. Louis</i>			22c. DATE SIGNED <i>9-14-62</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/17/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>				23d. LOCATION (City, town, or county) <i>St. Louis Co, Missouri</i>			
24. FUNERAL DIRECTOR <i>Alexander &amp; Sons</i>						ADDRESS <i>6175 Delmar Blvd. St Louis</i>		25. DATE RECD. BY LOCAL REG. <i>SEP 14 1962</i>		26. REGISTRAR'S SIGNATURE <i>Roan 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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Joe E. McCullough  
Licensed Embalmer No. 2460

P. O. Address 67 Oldman

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.