MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

10431

791

1003

File No. 2419

Registered No.

1. PLACE OF DEATH

County

Township

City St. Louis Mo (No. 4538 Lexington ave St. Ward)

Registration District No.

Primary Registration District No.

2. FULL NAME Emma Grant

(a) Residence. No. 4538 Lexington St., 10 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Wm A Grant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14 - 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	62	8	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Charles
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Carl Buce

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Marie Temperlune

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany

14. INFORMANT William A Grant
(Address) 4538 Lexington ave

15. FILED ....., 19.... Mae C Parker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1929, to March 8 1930 that I last saw h. alive on March 6 1930 and that death occurred, on the date stated above, at 7 30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
131
9.0.6.
(duration) ✓ yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis (duration) ✓ yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Urinal Albumin +
(Signed) Chas Rehn M. Hyde M. D.
3-9 1930 (Address) 3535 N. Newstead Av

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Charles Mo — DATE OF BURIAL 3/10 30

20. UNDERTAKER Stood & Carroll — ADDRESS 4400 North Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD