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.

REC'D SEP 12 1938

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

27093
Do not use this space.

Registration District No. 791
Primary Registration District No. 1003
Registered No. 7107

1. PLACE OF DEATH
(a) County
(b) Township
(c) City St. Louis (d) Street No. 5756 DeGiverville Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Homer W. Granade
(a) Residence, No. 5756 DeGiverville Ave. St. 6
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Granade

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 14, 1865

7. AGE: Years 72 | Months 7 | Days 24 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Cons't. ForeMan
9. Industry or business in which work was done, as saw mill, bank, etc. Western-Union
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

FATHER
13. NAME Homer W. Granade
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ga.

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Mrs. Elizabeth Granade
(ADDRESS) 5756 DeGiverville Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Oak Grove Cem. DATE Aug. 11, 1938

19. FUNERAL DIRECTOR (NAME) Arthur J. Donnelly
(ADDRESS) 3840 Lindell Blvd.

20. FILED AUG 11 1938 J. H. Biedeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 8, 1938, 19

22. I HEREBY CERTIFY, That I attended deceased from June 22nd, 1938, to August 8th, 1938
I last saw him alive on August 7th, 1938. Death is said to have occurred on the date stated above, at 5:30 pm.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral apoplexy (Hemorrhage)	8/7-38
not surgical	

Other contributory causes of importance:

Chronic Myo-Carditis	6/22-38

Name of operation — Date of —
What test confirmed diagnosis? Clinical Symptoms Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury —, 19—
Where did injury occur? —
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury —
Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify —
(Signed) O. H. Fries, M. D.
(Address) 1544 So. Broadway

Licensed Embalmer's Statement on Reverse Side)

Home 3209 Shenandoah
7-8 AM
1-2 PM
5-6 PM
Office 1544 S. Bury
9-10 AM
3-4 PM
7-8 PM

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 4204 Prairie

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.