

1-2-40
7-39
X23159

Registration District No. 791
Primary Registration District No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County
(b) City or town **SAINT LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **SAINT LUKES HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 DAYS**
(Specify whether
In this community **MOST OF LIFE**
years, months or days)

3. (a) PRINT FULL NAME **ANNIE M. GRIER.**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **FEMALE**
5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **MARCH 10 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 6 3 hr. min.

9. Birthplace **PEORIA ILLINOIS**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE (AT HOME)**

11. Industry or business

12. Name **DAVID P. GRIER**

13. Birthplace **PENNSYLVANIA**
(City, town, or county) (State or foreign country)

14. Maiden name **ANNA MCKINNEY**
15. Birthplace **PENNSYLVANIA**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS M. G. TODD**

(b) Address **496I LACLEDE AVE.**

17. (a) **BURIED** (b) Date thereof **SEPT 16 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BELLEFONTAINE CEM.**

18. (a) Signature of funeral director **C. R. LUPTON SONS.**

(b) Address **7233 DELMAR BLVD.**

19. (a) **SEP 14 1940** (b) *J.P. Proctor*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County

(c) City or town **SAINT LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **496I LACLEDE AVENUE.**
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **13**
year **1940** hour **7** minute **15 PM.**

21. I hereby certify that I attended the deceased from **Sept**
1937 to **Sept 13 1940**

that I last saw her alive on **Sept 13 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **CARCINOMA OF BREAST 3 yrs**

Due to **20**

Due to **20**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **RADICAL REMOVAL OF BREAST**
Of operations **DR. 13 KENS**

Of autopsy **Sept. 1937**

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature *J.P. Proctor* (M. D. or other)

Address **37. South Main** Date signed **9-15-40**

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 *Clarence H. Murray*

Licensed Embalmer No. *4011*

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 this body is not embalmed, fact should be so stated above.