

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **40560**  
Registrar's No. **10331**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Lukes Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 1/2 Mon.  
(Specify whether  
In this community Life Time  
years, months or days)

3. (a) PRINT FULL NAME Robert Cooper Grier

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Magery Chase Grier 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased June 20 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 5 25 hr. min.

9. Birthplace Peoria Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Lawyer

11. Industry or business Retired

12. Name David P. Grier  
13. Birthplace Danville Pa.  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Mc Kinney  
15. Birthplace Penn.  
(City, town, or county) (State or foreign country)

16. (a) Informant David P. Grier  
(b) Address 105 Adams St. Chicago Ill.

17. (a) Burial (b) Date thereof 12/17/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Wagoner Und. Co.

(b) Address 3621 Olive St. Louis, Mo.

19. (a) DEC 17 1940 (b) J. F. Bredich  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Clayton's  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7913 Kingsbury Blvd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? N.A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15  
year 1940 hour 4:50 P.M. M.

21. I hereby certify that I attended the deceased from Aug. 1, 1940 to Dec. 15, 1940;  
that I last saw him alive on Dec. 15, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory + respiratory failure

Due to Uremia + toxemia

Due to Chronic bilateral pyelonephritis - 5 yrs.

Other conditions Chronic cystitis, noncalculous  
(Include pregnancy within 3 months of death)  
non pyogenic non tubercular  
Paralysis agitans 6 yrs.  
Non calculous

Major findings: Of operations 876

Of autopsy 876

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 W. T. Baruhart (M. D. or other) g. d.  
Address 3720 Washington Date signed Dec. 16, 1940

Dr. J. H. Sanford  
Barnwood Bldg.

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

Signed

*Neville D. Proctor*

Licensed Embalmer No. 3696

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, above space should be left blank.