No. 2
-1-4-41
5-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 28 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36160

Registration District No. 78 Primary Registration District No. 25 Registrar's No. 219

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 1 mo. 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County — 000
(c) City or town St. Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No. 2360 Lawrence (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alice Grape
3. (b) If veteran, name war
3. (c) Social Security No. no
4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Alex Grape 6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased 11 (Month) – 16 (Day) – 74 (Year)

8. AGE: Years 66 Months 11 Days 1 If less than one day ___ hr. ___ min.

9. Birthplace Omaha (City, town, or county) Neb. (State or foreign country)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name John McConnell
13. Birthplace Belfast (City, town, or county) Ireland (State or foreign country)
MOTHER 14. Maiden name Elizabeth Harding
15. Birthplace New Jersey (City, town, or county) (State or foreign country)
16. (a) Informant Robert Koch Hosp.
(b) Address Records
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20/41 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Pk.
18. (a) Signature of funeral director Weick Bros.
(b) Address 2201 So. Grand Blvd.
19. (a) OCT 19 1941 (Date received local registrar) (b) E. S. McSharron (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17 year 1941 hour 10 minute 35 p. M.
21. I hereby certify that I attended the deceased from 9-16-41, 19..., to 10-17-41, 19...; that I last saw her alive on 10-17-41, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Approx. 2 yrs.
Due to
Due to
Other conditions Gen. Arteriosclerosis (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature William Stanbro (M. D. or other) MD
Address Robt Koch Hosp. Date signed 10-18-41

(Licensed Embalmer's Statement on Reverse Side)

OCT 21 1947

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.....Francis A Williamson

Licensed Embalmer No.....3565

P. O. Address.....7401 Zephyr Pl

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

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