

ED JUN 19 1943
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 MO.**
In this community **6 months**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No. **818 Biddle St.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Bessie Pearl Grayer**

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

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Harvey Grayer** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **June 1, 1913**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 0 3 hr. min.

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

10. Usual occupation **Unknown**

11. Industry or business.....

12. Name **Chester Simon**

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

14. Maiden name **Mary Cook** (City, town, or county) (State or foreign country)

15. Birthplace **Tenn.** (City, town, or county) (State or foreign country)

16. (a) Informant **Shirley M. Smith**

(b) Address **2601 N. Whittier**

17. (a) **Removal** (b) Date thereof **6-7-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Madrid, Mo**

18. (a) Signature of funeral director **Richard J. Service**

(b) Address **New Madrid, Mo**

19. (a) **6/7/43** (b) **J. F. Bredeck**
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **4**
year **1943** hour **10** minute **50 A. M.**

21. I hereby certify that I attended the deceased from **May 4, 1943** to **June 4, 1943**

that I last saw her alive on **June 4, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis** Duration **Indef.**

Due to.....

Due to.....

Other conditions (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 **Alleg. Mace** (M. D. or other)

Address **2601 Whittier** Date signed **6/7/43**

Reclaimed from Anatomical Board (Licensed Embalmer's Statement on Reverse Side) **6-7-43**

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

5-42
17-39
X325

5425

5425

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
BUREAU OF HEALTH CARE REGULATION
1500 CALIFORNIA STREET, SACRAMENTO, CALIFORNIA 95833
TELEPHONE (916) 227-8000

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19629

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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: Homer S. Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. (Specify whether
in this community 6 mo. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bessie Pearl Gruyer

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m

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

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

8. AGE: Years 30 Months 0 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JUN 25 1943 (b) J. F. Budick (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____.

that I last saw him/her alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY--USE INK--BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

11w 21q

S-19629