S. No. 2
OM—2-43
5-47-3
1 X3

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30175

FILED OCT 2 - 1943 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 8395

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: Deaconess Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether

In this community years, months or days)

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. 5864 Enright Ave., (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Grant McFetridge

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased May (Month) 8 (Day) 1886 (Year)

8. AGE: Years 57 Months 4 Days 9 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business Building

FATHER
12. Name Wm. McFetridge
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Bessie Brooks

(b) Address 5864 Enright Ave/

17. (a) Burial (Burial, cremation, or removal). (b) Date thereof 9-27-43 (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.,

19. (a) SEP 21 1943 (Date received local registrar) (b) J. Fredrich (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1943 hour 11 45 minute A M.

21. I hereby certify that I attended the deceased from Sept 1st 1943, to Sept 17 1943 that I last saw him alive on Sept 17 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Prostatic Hypertrophy — Duration XX; Hypertension Arterial — XX

Due to Forfeited G. M. Tract. Staphylococcus — XX

Due to Surgical Shock, Operation 9/17/43

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Hypertrophy of Prostate, Calcified Stones

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 Guy Simpson (M. D. or other) MD

Address 3833 Washington Date signed 9/21/43

(Licensed Embalmer's Statement on Reverse Side)

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 comply with the above constitutes grounds for revocation of license.)

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