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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 21 1944

State File No. 8989
Registrar's No. 2465

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(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 22 days
In this community 21 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Stella Mae Grant
3. (b) If veteran, name war No. 3. (c) Social Security No.

4. Sex Female 5. Color or Race Col 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 8/6/1921 (Month) (Day) (Year)

8. AGE: 22 Years Month 7 Day 34 If less than one day
~~83~~ 1921 ~~8~~ 3 hr. min.

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

10. Usual occupation Housework House

11. Industry or business

MOTHER FATHER

12. Name Lewis Grant

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

14. Maiden name Mary Wolford

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

16. (a) Informant Mary Johnson

(b) Address 2223 Walnut

17. (a) Burial (b) Date thereof 3/14/1944 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery.

18. (a) Signature of funeral director Atkins Undertaker Co.
(b) Address 3644 Finney Ave.

19. (a) MAR 14 1944 (Date received local Registrar) (b) J. F. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 172
(c) City or town St. Louis, 92
(If outside city or town limits, write "RURAL")
(d) Street No. 2326 Eugenia (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 10, day 10, year 1944 hour 2 minute 25 A. M.
21. I hereby certify that I attended the deceased from February 17, 1944 to March 10, 1944 that I last saw her alive on March 10, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis (far advanced) Unk.
Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
13 hr

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 Alva [Signature] (M. D. Physician)
Address 2306 [Signature] Date signed 3/14/44

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

Clark Young

Licensed Embalmer No.

33710

P.O. Address

St. Louis

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.