

No. 4
8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 24 1945
Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18088
Registrar's No. 964

Primary Registration District No. 3069

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 2906 N. Vandeventer
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM GRACE
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 25 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>4</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Police Officer

11. Industry or business St. Louis Met Police Dep

12. Name Patrick Grace

13. Birthplace England 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace England 4
(City, town, or county) (State or foreign country)

16. (a) Informant Virginia Grace

(b) Address 2906 N. Vandeventer

17. (a) Burial (b) Date thereof 4/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director SULLIVAN BRO'S
2849 N. Euclid ave

(b) Address _____
19. (a) APR 21 1945 (b) E. G. McEwen, MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
year 1945 hour 9 minute 35 A. M.
21. I hereby certify that I attended the deceased from April 4
1945 to April 17 1945
that I last saw him alive on April 16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration about 1 day
Due to degenerative heart disease
Due to a 30

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: degenerative heart disease 4/4/45
Of operations _____ PHYSICIAN
Of autopsy _____ 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) (Specify means of injury)
23. Signature E. G. McEwen (M. D. or other) _____
Address 2849 N. Euclid Ave Date signed 4/18/45

Dr. E. J. KOHLER

4968a Delmar Blvd

To 4350

11-2 P.M. Wed

MAY 25 1943

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

working under my personal supervision.

Registered Apprentice No.

Signed

Robert L. Pinkman

Licensed Embalmer No.

3553

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 964

Registration District No. 317 Primary Registration District No. 3069

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ 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 Wm Grace

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

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

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) E. P. McQuinn MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

18088