

FILED AUG 3 1945
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 _____
(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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Hrs. 55 Mins.
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 907 N. 16th Street
(If rural, give location) 025
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Thomas Grant

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased 7 7 45
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 5 hr. 55 min.

9. Birthplace St. Louis 0
(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 Odessa Grant

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

16. (a) Informant Mary T. Duwell
(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof JUL 26 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. P. Hudson
(b) Address City Health Dept

19. (a) JUL 20 1945 J. J. Brubaker
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 7
year 1945 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from 5:55 P.M.
7 - 7, 1945 to 11:50 P.M. 7-7, 1945,
that I last saw him alive on 7 - 7, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

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)
(c) Means of injury 0

23. Signature W. J. Simpson M.D. (X3056)
Address 2601 N. Whittier Date signed 7-12-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.