

FILED SEP 4 1945 317

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Manchester Nursing Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 months  
(Specify whether years, months or days) In this community 70 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5861 Plymouth  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CLARENCE C. GRIERSON

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Married  
6. (b) Name of husband or wife Rita Doyle Grierson 6. (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased (Month) 7 (Day) 16 (Year) 1871

8. AGE: Years 74 Months 1 Days 8 If less than one day hr. min.

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

10. Usual occupation Ret'd Haberdashery

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Robert Grierson  
13. Birthplace Dublin Ireland (City, town, or county) (State or foreign country)  
14. Maiden name Sarah Mc Farland  
15. Birthplace County Tyrone Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clarence Grierson  
(b) Address 5861 Plymouth

17. (a) Burial (b) Date thereof 8-27-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Alexander & Sons  
(b) Address 6175 Delmar Blvd - St. Louis

19. (a) 8-29-45 (b) C. H. Mc Gowan  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24 year 1945 hour 55 minute P.M.

21. I hereby certify that I attended the deceased from July? 1944, to Aug 24 1945; that I last saw him alive on Aug 24 1945; and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis, senility Duration \_\_\_\_\_

Due to generalized arteriosclerosis

Due to 936

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 \_\_\_\_\_

Signature A. L. Mefflin M.D. (M. D. optional) Address 3507 Potomac Date signed 8-25-45

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

Dr. Anton L. Micklin  
462 N. Taylor  
1-230 PM

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 Thomas R. Demwick  
Licensed Embalmer No. 3793  
P. O. Address St Louis, Mo

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.