S. No. 2
M—2-43
. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31437

State File No.

FILED OCT 6 1945

Registration District No. 0176

Primary Registration District No. 6076

Registrar's No. 2317

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Mount St. Rose Sanitarium 0
(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 Illinois (b) County Franklin 999

(c) City or town West Frankfort 11
(If outside city or town limits, write "RURAL")

(d) Street No. 107 W. 8th St. 0
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME THOMAS L. GRADY

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased September (Month) 22 (Day) 1905 (Year)

8. AGE:

Years	Months	Days	If less than one day
40	0	8	hr. min.

9. Birthplace Spillertown (City, town, or county) Illinois 1 (State or foreign country)

10. Usual occupation Coal Miner

11. Industry or business

FATHER
12. Name Thomas J. Grady
13. Birthplace Unknown (City, town, or county) Pennsylvania 1 (State or foreign country)

MOTHER
14. Maiden name Nora Boyd
15. Birthplace Unknown (City, town, or county) Illinois 1 (State or foreign country)

16. (a) Informant Mrs. Virgil Rich
(b) Address West Frankfort, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Spillertown, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) 10-4-45 (Date received local registrar) (b) E. G. McGovran MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30 year 1945 hour 5 minute 50 P.M.

21. I hereby certify that I attended the deceased from July 7, 1945, to Sept 30, 1945, that I last saw him alive on Sept 30, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Far Advanced Pulmonary Tuberculosis	4 yrs.
Due to 13b	
Due to	
Other conditions Tbc Enteritis (Include pregnancy within 3 months of death)	1 yr

Major findings:
Of operation None

Of autopsy Perforated Tbc ulcer of ileum c̄ generalized peritonitis

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 John C. Murphy (M. D. or other) MD
Address 9101 So. Broadway Date signed 9/30/45

(Licensed Embalmer's Statement on Reverse Side)

OCT 10 1945

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 Elmo P. Sadwell

Licensed Embalmer No. 4077

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.