

No. 2
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THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 27 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **441**

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 **7 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **n 3647 Finney Ave.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **10**
 year **1947** hour **4** minute **30 P** M.
 21. I hereby certify that I attended the deceased from **1-3-** 19 **47** to **1-10** 19 **47**
 that I last saw him alive on **Jan. 10** 19 **47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Meningitis, Non-specific**
 Duration **Undet.**
 Due to _____
 Due to _____
 Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy **Yes**
 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 **Thodore Levin** (M.D. or other) _____
 Address **2601 N Whittier** Date signed **1/13/47**

3. (a) PRINT FULL NAME **James H. Grady (Jimmie)**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **Col**
 6. (a) Single, widowed, married, divorced **child**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Oct. 13 1944**
(Month) (Day) (Year)

8. AGE: Years **2yrs** Months **2** Days **27**
 If less than one day _____ hr. _____ min.

9. Birthplace: **Missouri** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____
 12. Name **James Grady**

13. Birthplace **Ill.** **1**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Veal** **1**
 15. Birthplace **Miss.** **1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elizabeth Bell**

(b) Address **3647 Finney Ave.**

17. (a) **Burial** (b) Date thereof **1-15-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **Albin Bros. M.D.**
 (b) Address **3644 Finney Ave.**
 19. (a) **JAN 14 1947** (b) **J.F. Budalich**
(Date received local registrar) (Registrar's signature)

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

Louis V. Atkinson

Licensed Embalmer No.

2842

P. O. Address

3644 Firme

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.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(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

3. (a) PRINT FULL NAME

James H. Gady

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Oct 13 (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) MO

10. Usual occupation _____

11. Industry or business _____

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 14 1947 (b) J. F. Brebeck (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month _____, Year 1947, hour _____, minute _____ M.

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

Duration _____

Due to _____

Due to _____

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

FEB 5 1947

2543