S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 18 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39326

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 192

1. PLACE OF DEATH:

(a) County St. Charles County

(b) City or town St. Charles, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution entered 10-6-47 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Montgomery 70

(c) City or town Montgomery 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James Peter Grennan

3. (b) If veteran, name war No.

3. (c) Social Security No. none

4. Sex M. 0

5. Color or race White

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Ada Gertrude Grennan

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased 9 (Month) 20 (Day) 1864 (Year)

8. AGE:

Years	Months	Days	If less than one day
83	0	18	hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name James Peter Grennan 4
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ann E. Worland
15. Birthplace Ky. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Ada Gertrude Grennan
(b) Address Montgomery City MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-47 (Month) (Day) (Year)
(c) Place: burial or cremation St Marys Cemetery

18. (a) Signature of funeral director Cecil of Rivers
(b) Address Montgomery City Mo

19. (a) 11-4-47 (Date received local registrar) (b) Naomi Hamilton (Registrar's signature) 144

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 8 year 1947 hour 1 minute 25 P. M.

21. I hereby certify that I attended the deceased from 10-6-47, 19__, to 10-8, 1947; that I last saw him alive on Oct 8, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	
Due to hypertensive heart disease	
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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature Ira L. Faith MD (M. D. or other)

Address 207 N 7th St St Charles Date signed 10/8/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 11-12-47

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~~ on the 8th day Oct 1947, Registered Apprentice No. ....., working under my personal supervision.

Signed C. L. Hopkins

Licensed Embalmer No. 1487

P. O. Address Mantgomery 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.