

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20899**
Registrar's No. **5422**

FILED JUN 23 1948

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: City Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **JAMES GRANT**

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ida May 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Dec 23 1878
(Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days 21 If less than one day
hr. _____ min.

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

10. Usual occupation Maintaince

11. Industry or business _____

12. Name John Grant

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

14. Maiden name Standley
(City, town, or county) (State or foreign country)

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

16. (a) Informant Peter Grant

(b) Address 1833a Shields

17. (a) Burial (b) Date thereof 6/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Puxico

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 1104 Manchester Ave.

19. (a) JUN 15 1948 (b) J. J. Bralock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard
(c) City or town Puxico
(If outside city or town limits, write "RURAL")
(d) Street No. N.R.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th
1948 year hour 7:15 minute A. M.

21. I hereby certify that I attended the deceased from May 24 to June 14
1948, 1948 that I last saw him alive on June 14
and that death occurred on the date and hour stated above.

Immediate cause of death
Generalized Arteriosclerosis 1948x
Cerebral Arteriosclerosis 1948x.

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) (a) Means of injury _____

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

Address _____ Date signed _____

Duration

1948x
1948x.

PHYSICIAN

Underline the cause to which death should be charged statistically.

5422

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..... *J. Allen Davis*.....

Licensed Embalmer No. *4053*.....

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.