

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38772
9590

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St Louis Mo)		c. LENGTH OF STAY (in this place) 5 mos 30 days		c. CITY (If outside corporate limits, write RURAL and give township) Flat River Mo		d. STREET ADDRESS (If rural, give location) NR - Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Louis Childrens H							
3. NAME OF DECEASED (Type or Print)		a. (First) Judith		b. (Middle) Gayle		c. (Last) Grenia	
4. DATE OF DEATH		(Month) 11		(Day) 7		(Year) 49	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ↓		8. DATE OF BIRTH 1-14-48	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elvins, Mo		12. CITIZEN OF WHAT COUNTRY? Spaniards	
13a. FATHER'S NAME Francis Gayle Grenia		13b. MOTHER'S MAIDEN NAME Norma Jean Leonard		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Norma Jean Leonard Grenia			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculous meningitis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ROCK			
22. I hereby certify that I attended the deceased from 5-8 , 1949, to 11-7 , 1949, that I last saw the deceased alive on 11-7 , 1949, and that death occurred at 12:15 AM. , from the causes and on the date stated above.							
23a. SIGNATURE Wm G Klingberg MD		(Degree or title)		23b. ADDRESS Childrens Hosp.		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 11/9/49		24c. NAME OF CEMETERY OR CREMATORY Woodlawn		24d. LOCATION (City, town, or county) (State) Flat River Mo	
DATE REC'D BY LOCAL REG. NOV 7 1949		REGISTRAR'S SIGNATURE J. B. ...		25. FUNERAL DIRECTOR'S SIGNATURE Sparky Loyal Home		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Murphy L Sparks

Licensed Embalmer No. *4287*

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.