

FILED MAR 8 - 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6950

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>3063</b>		Registrar's No. <b>167</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Louis County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Clayton</b>		c. LENGTH OF STAY (in this place) <b>2 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Robertson</b>		14000	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>Woodland Street</b>			
3. NAME OF DECEASED (Type or Print) <b>GARFIELD</b>		a. (First) <b>J</b>		b. (Middle) <b>GRANT</b>		c. (Last)	
4. DATE OF DEATH		(Month) <b>FEB.</b>		(Day) <b>17</b>		(Year) <b>1950</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>color</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>		8. DATE OF BIRTH <b>05 16 1911</b>	
9. AGE (In years last birthday) <b>39</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during part of work life, even if retired) <b>porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Robertson Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Jackson Grant</b>		13b. MOTHER'S MAIDEN NAME <b>Carrie Grant</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>481-18-0632</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Carrie Grant Robertson Mo</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>(a) Pulmonary tuberculosis, advanced</b>  ANTECEDENT CAUSES Morbid 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 checked="" type="checkbox"/> NO <input 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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>Feb. 16</b> , 1950, to <b>Feb. 17</b> , 1950, that I last saw the deceased alive on <b>Feb. 17</b> , 1950, and that death occurred at <b>3:05 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>R.R. Cable, M.D.</b>				23b. ADDRESS <b>601 S. Brentwood Clayton 5, Mo.</b>		23c. DATE SIGNED <b>2-17-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>FEB 23 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>F.B. National Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Jefferson Co. Mo.</b>	
DATE REC'D BY LOCAL REG. <b>FEB 22 1950</b>		REGISTRAR'S SIGNATURE <b>Robert H. Adams, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Adams, M.D.</b>		ADDRESS <b>Robertson Mo</b>	

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

APR 19 1950

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.

Signed

*Herbert J. Yandee*

Signed.....

Student Embalmer

Licensed Embalmer No. *4243*

P. O. Address *1306 Ludge*

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.