

FILED AUG 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

State File No. 28229
Registrar's No. 6926

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2219

d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital

d. STREET ADDRESS (If rural, give location) 2702 Stoddard

3. NAME OF DECEASED
a. (First) Lee b. (Middle) _____ c. (Last) Grant

4. DATE OF DEATH (Month) (Day) (Year)
August 7 1950

5. SEX M

6. COLOR OR RACE Col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH May 1876

9. AGE (In years last birthday) 79 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 6 HRS: Hours _____ Mins. _____

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) labor

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) Ark

12. CITIZENSHIP OF WHAT COUNTRY? _____

13a. FATHER'S NAME George Grant

13b. MOTHER'S MAIDEN NAME Henriette Billups

14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sela Morgan Baldwin Medicine

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* (a) Myocardial Infarction

ANTECEDENT CAUSES
DUE TO (b) Hypertensive Heart Disease
DUE TO (c) Undetermined

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
Un det.

''

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? H2O

22. I hereby certify that I attended the deceased from 7-22, 1950, to 8-7, 1950, that I last saw the deceased alive on 8-7, 1950, and that death occurred at 1:30p m., from the causes and on the date stated above.

23a. SIGNATURE Alvin Thompson (Degree or title) _____

23b. ADDRESS 2601 N Whittier St

23c. DATE SIGNED 8-9-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried

24b. DATE Aug 14/50

24c. NAME OF CEMETERY OR CREMATORY Father's Dickson

24d. LOCATION (City, town, or county) (State) St Louis MO

DATE REC'D BY LOCAL REG. AUG 15 1950

REGISTRAR'S SIGNATURE J. B. Sasser

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. L. Shew 4214 Delmar

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *F. G. Green*

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.