

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34840**  
**8348**  
Registrar's No.

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis 2109</b>		d. STREET ADDRESS (If rural, give location) <b>3115 WHITTIER ST</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>									
3. NAME OF DECEASED (Type or Print) a. (First) <b>John t</b> b. (Middle) <b>J</b> c. (Last) <b>Grant</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 30 1950</b>						
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>		8. DATE OF BIRTH <b>Feb 8-1889</b>		9. AGE (In years last birthday) <b>61 YRS</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>JOHN GRANT</b>			13b. MOTHER'S MAIDEN NAME <b>MARY BERRY</b>		14. NAME OF HUSBAND OR WIFE <b>NORAH GRANT</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Mary Nilgey 3115 Whittier St</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u><b>Pulmonary tuberculosis, far advanced</b></u> ANTECEDENT CAUSES DUE TO (b) <u><b>Carcinoma of lungs</b></u> DUE TO (c) <u><b>Carcinoma of Esophagus</b></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u><b>Cerebral thrombosis</b></u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>150X</b>					
22. I hereby certify that I attended the deceased from <u><b>Sept. 3</b></u> , 19 <u><b>50</b></u> , to <u><b>Sept. 30</b></u> , 19 <u><b>50</b></u> , that I last saw the deceased alive on <u><b>Sept. 30</b></u> , 19 <u><b>50</b></u> , and that death occurred at <u><b>2:10 P. M.</b></u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Robert Kuyken M.D.</b>				23b. ADDRESS <b>1515 Lafayette Ave.,</b>		23c. DATE SIGNED <b>10/1/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>OCT 4-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>			
DATE REC'D BY LOCAL REG. <b>OCT 3 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Foster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E. J. Schurer 3125 Lafayette Ave.</b>					

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 Geo. B. Hollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave

**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.