

FILED APR 20 1951

STANDARD CERTIFICATE OF DEATH 1003

State File No. 14131

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. 3133		
1. PLACE OF DEATH a. COUNTY 1				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (If in this place) 15 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1127 N. 19th St				d. STREET ADDRESS (If rural, give location) 1127 No. 19th Street				
3. NAME OF DECEASED (Type or Print) Huston			a. (First)		b. (Middle)		c. (Last) Grant	
4. DATE OF DEATH		(Month) Apr.		(Day) 1		(Year) 1951		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Feb. 20, 1889		
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months 1 Days 12		IF UNDER 24 HRS. Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Louisville, Ky.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13a. FATHER'S NAME unknown			13b. MOTHER'S MAIDEN NAME unknown			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) no			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Elizabeth Grant ADDRESS 2819r Sheridan Av.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encephalomalacia		ANTECEDENT CAUSES						
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Arteriosclerosis of Cerebral vessels						
DUE TO (c) Cerebral vessels		II. OTHER SIGNIFICANT CONDITIONS						
Conditions contributing to the death but not related to the disease or condition causing 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 232X				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.								
23a. SIGNATURE [Signature] (Degree or title) _____				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 4/2/51		
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 4-5-51		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		
DATE REC'D BY LOCAL REG. APR 4 1951		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Dement & Son ADDRESS 2629-31 Cole St				

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

W. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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.