.S. No. 300
EV. 10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10012

BIRTH NO. MAR 29 1952 17367 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2473

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis, Mo.
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): De Paul Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 20
d. STREET ADDRESS (If rural, give location): 6 5251 Cote Brilliante

3. NAME OF DECEASED (Type or Print)
a. (First): Carol-Sue
b. (Middle):
c. (Last): Grass

4. DATE OF DEATH (Month) (Day) (Year): 3-14-52

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: March 13th 1952
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 22 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): St Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Russell Grass
13b. MOTHER'S MAIDEN NAME: Anna Lou Greenwell
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: Russell Grass ADDRESS: 5251 Cote Brilliant

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Atelectasis of Left lung — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Foetal
DUE TO (c)

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 ☑ 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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 762.0

22. *I hereby certify that I attended the deceased from* 3-13-, 1952, *to* 3-14-, 1952, *that I last saw the deceased alive on* 3-14-, 1952, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Herman J. Kloeber (Degree or title) M.D.
23b. ADDRESS: 9651 Lackland Rd.
23c. DATE SIGNED: 3-14-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 4
24b. DATE: 3-15-52
24c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
24d. LOCATION (City, town, or county) (State): St Louis County Mo.

DATE REC'D BY LOCAL REG.: MAR 15 1952
REGISTRAR'S SIGNATURE: J. Earl Smith M.D. G.P.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Kraeger-Fenwick 3402 N. Kingshighway

(Licensed Embalmer's Statement on Reverse Side)

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 No Embalming

Licensed Embalmer No. _____

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.