

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **15795**
Registrar's No. **3952**FILED MAY 14 1953 BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		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, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda General Hospital		d. STREET ADDRESS (If rural, give location) 5 5883 Julian	
3. NAME OF DECEASED (Type or Print) a. (First) Grace b. (Middle) T. c. (Last) Herod			4. DATE OF DEATH (Month) (Day) (Year) April 14 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 3, 1888
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months 7	IF UNDER 12 HRS. Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Marissa, Illinois
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Joseph Henry		13b. MOTHER'S MAIDEN NAME Carrie Coyle	14. NAME OF HUSBAND OR WIFE Mathew Herod
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. 492-22-8080	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. C.E. Schuster, 2422 Bremerton Rd.
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Primary Carcinoma Ovary (Left) 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.	
19a. DATE OF OPERATION Oct. 5, 1951		19b. MAJOR FINDINGS OF OPERATION Carcinoma Left Ovary.	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 175X			
22. I hereby certify that I attended the deceased from Jan 1951 to Apr 14, 1953 , that I last saw the deceased alive on Apr 14, 1953 , and that death occurred at 5:30 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. E. Smith M.D.		23b. ADDRESS 4500 Olive St. Louis 8 Mo. 63105-52	
23c. DATE SIGNED 4-17-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-17-53	
24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. APR 16 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE JAY B. SMITH, Maplewood, Mo.		ADDRESS	

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.....

H. Burgess

Signed.....

Student Embalmer

Licensed Embalmer No. *4029*

P. O. Address. *Maplewood*

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.